Supreme Court, U.S
FILED

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No. OFFICE OF THE CLERK

In the Supreme Court of the United States

October Term, 1997

NANCY M. SMITH AND
JOSEPH L. SMITH, HER HUSBAND

Petitioners

vs.

THE HARTFORD INSURANCE GROUP; THE PROVIDENT LIFE AND ACCIDENT INSURANCE GROUP; NATIONAL MEDICAL ENTERPRISES, INC.; NATIONAL MEDICAL SPECIALTY HOSPITAL GROUP; PSYCHIATRIC INSTITUTES OF AMERICA HEALTH CARE GROUP; PENNSYLVANIA HEALTH CORP., D/B/A THE REHAB HOSPITAL IN MECHANICSBURG; P.I.A. VOLUNTARY EMPLOYEES BENEFICIARY ASSOCIATION GROUP INSURANCE PLAN; AND P.I.A. VOLUNTARY EMPLOYEES BENEFICIARY ASSOCIATION ADMINISTRATIVE COMMITTEE,

Respondents

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

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STATEMENT OF THE QUESTIONS PRESENTED FOR REVIEW

I. May an employer *constitutionally* change the medical benefit provisions of an ERISA plan or change plans that eliminate or reduce contractually mandated benefits *after* an employee has already sustained a catastrophic disability and *is receiving benefits at the time of the change?*

II. Is a plaintiff entitled to attorneys' fees under ERISA regardless of whether or not the plaintiff was a "prevailing party," where the plaintiff conducted seven years of complex litigation that served to advance the law or, in the alternative, where the plaintiff was the prevailing party but was awarded no damages or, alternatively, where the trial court under *appropriate* legal bases held that plaintiff was entitled to attorneys' fees but later reversed its position on the *improper* basis that the substitute insurance policy did not provide for attorneys' fees?

PARTIES TO THE PROCEEDING

The parties to the proceeding are Petitioners Nancy and Joseph Smith and Respondent Pennsylvania Health Corp. d/b/a The Rehab Hospital in Mechanicsburg.

TABLE OF CONTENTS

PAGE

Statement of the Questions Presented for Review . . . i

Parties to the Proceedings ii

Table of Contents iii

Table of Citations vi

Petition 1

Reference to the Opinions Delivered in the Courts Below 2

Statement of Jurisdiction 3

Statutory Provision Involved 4

Statement of the Case:

A. Facts 5

B. Procedural History 7

Reasons for Allowance of the Writ:

I. An Employer May Not Constitutionally Change The Medical Benefit Provisions Of An ERISA Plan Or Change Plans That Eliminate Or Reduce Contractually Mandated Benefits After An Employee Has Already Sustained A Catastrophic Disability And Is Receiving Benefits At The Time Of The Change 10

II. A Plaintiff Is Entitled To Attorneys' Fees Under ERISA Regardless Of Whether Or Not The Plaintiff Was A "Prevailing Party," Where The Plaintiff Conducted Seven Years Of Complex Litigation That Served To Advance The Law Or, In The Alternative,

Where The Plaintiff Was The Prevailing Party But Was Awarded No Damages Or, Alternatively, Where The Trial Court Under Appropriate Legal Bases Held That Plaintiff Was Entitled To Attorneys' Fees But Later Reversed Its Position On The Improper Basis That The Substitute Insurance Policy Did Not Provide For Attorneys' Fees 17

Conclusion 22

APPENDIX:

Order of the Third Circuit Court of Appeals, En Banc, Nos. 96-7297 and 96-7328, dated May 14, 1997 . . 1a

Order of the Third Circuit, Nos. 96-7297 and 96-7328, dated March 28, 1997 . . . . . 4a

Opinion of the United States District Court for the Middle District of Pennsylvania, No. 1:CV-90-1541, dated April 26, 1996 . . . . . 6a

Order 28a

Order of the United States District Court, dated September 20, 1995 . . . . . 29a

Memorandum of the United States District Court, dated September 5, 1995 . . . . . 32a

Order 50a

Memorandum and Order of the United States District Court, dated February 16, 1995 . . . . . 52a

Order and Memorandum of the United States District Court, dated February 16, 1995 . . . . . 55a

Opinion of the Third Circuit Court of Appeals No. 92-7310, filed October 4, 1993 . . . . . 76a

Dissenting Opinion, Hutchinson, J., of the Third Circuit, filed October 4, 1993 . . . . . 97a

Memorandum and Order of the United States District Court, No. 1:CV-90-1541, dated June 2, 1992 . . . 108a

Memorandum of the United States District Court, dated April 16, 1992 . . . . . 111a

Order and Judgment 134a

Transition Provisions 135a

Relevant Portions of Original BC/BS Policy 136a

Relevant Portions of 1984 BC/BS Policy 139a

Letter, dated September 11, 1987 from Sandra J. Fertenbaugh to "To Whom It May Concern" . . . 145a

Letter, dated August 26, 1987 from P.G. Christian to Nancy M. Smith 146a

Letter, dated December 6, 1988 from Phillip Christian to Mr. Joseph Smith 148a

Letter, dated June 19, 1989 from Joseph L. Smith to Mr. Eakin 150a

Letter, dated July 14, 1989 from S.L. Downs to Mr. Joseph L. Smith 152a

Letter, dated August 2, 1989 from Joseph Smith to Mr. S.H. Downs 153a

Memorandum, dated November 8, 1989 from Shai M. Kyle to Employees with Hartford Medical/Dental Coverage 154a

Letter, from Provident Group Claim Service to Nancy M. Smith 156a

Letter, dated March 21, 1990 from Nancy Smith to Group Claim Service 158a

TABLE OF CITATIONS

CASES:

Allied Structural Steel Co. v. Spannaus, 438 U.S. 234 (1978) 16

Anthuis v. Colt Industries Operating Corp., 971 F.2d 999 (3d Cir. 1992) 21

Buell v. Security General Life Insurance Co., 987 F.2d 1467 (10th Cir. 1993), cert. denied, 510 U.S. 916 (1993) 13, 14

Commonwealth v. Walton, 182 Pa. 373, 38 A. 790 (1897) 10

Conkwright v. Westinghouse Electric Corp., 933 F.2d 231 (4th Cir. 1991) 14

Dister v. Continental Group, Inc., 859 F.2d 1108 (2d Cir. 1988) 14

Dodson v. Woodmen of the World Life Insurance Society, 109 F.3d 436 (8th Cir. 1997) 19

Hooper v. Demco, Inc., 37 F.3d 287 (7th Cir. 1994) . . 19

Hummell v. S.E. Rykoff & Co., 634 F.2d 446 (9th Cir. 1980) 18, 19, 21

Kross v. Western Electric Co., Inc., 701 F.2d 1238 (7th Cir. 1983) 14

Lawrence v. Westerhaus, 749 F.2d 494 (8th Cir. 1984) 19

McGann v. H & H Music Co., 946 F.2d 401 (5th Cir. 1991), cert. denied, 506 U.S. 981 (1992) 14

Miller v. United Welfare Fund, 72 F.3d 1066 (2d Cir. 1995) 18

Smith v. Hartford Insurance Group, 6 F.3d 131 (3d Cir. 1993) 8, 11, 12, 15

Sokol v. Bernstein, 812 F.2d 559 (9th Cir. 1987) 18

Ursic v. Bethlehem Mines, 719 F.2d 670
(3d Cir. 1983) 19, 21

Wheeler v. Dynamic Engineering, Inc., 62 F.3d 634
(4th Cir. 1995), cert. denied, U.S. . . . 13, 14

STATUTES:

Employment Retirement Income Security Act:

§502(a)(1)(B) 8

§502(a)(3) 8

§502(g) 18, 19, 20

29 U.S.C.

§1001 4

§1001(b) 16

§1132(a)(1)(B) 8

§1132(a)(3) 8

§1132(g) 20

Civil Rights Act of 1964, Title VII, 42 U.S.C.

§1983 18

§2000e-(k) 18

Copyright Act of 1976, 17 U.S.C. §505 18

Equal Access to Justice Act, 28 U.S.C. §2412 18

Clean Water Act, 33 U.S.C. §1251 18

OTHER AUTHORITIES:

U.S. Constitution, Article I, Section 10 15

Pennsylvania Constitution, Article 7, Section 17 15

Petition

IN THE SUPREME COURT OF THE UNITED STATES

NANCY M. SMITH AND JOSEPH L. SMITH,
Her Husband,

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vs.

THE HARTFORD INSURANCE GROUP; THE PROVIDENT LIFE AND ACCIDENT INSURANCE GROUP; NATIONAL MEDICAL ENTERPRISES, INC.; NATIONAL MEDICAL SPECIALTY HOSPITAL GROUP; PSYCHIATRIC INSTITUTES OF AMERICA HEALTH CARE GROUP; PENNSYLVANIA HEALTH CORP., D/B/A THE REHAB HOSPITAL IN MECHANICSBURG; P.I.A. VOLUNTARY EMPLOYEES BENEFICIARY ASSOCIATION GROUP INSURANCE PLAN; P.I.A. VOLUNTARY EMPLOYEES BENEFICIARY ASSOCIATION ADMINISTRATIVE COMMITTEE

Respondents

PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

To the Honorable, the Chief Justice and the Associate Justices of the Supreme Court of the United States.

REFERENCE TO THE OPINIONS DELIVERED IN THE COURTS BELOW

On May 14, 1997, the United States Court of Appeals for the Third Circuit denied the Smiths' Petition for Rehearing (App. 1a), from the Judgment of a Panel of the Third Circuit (App. 4a), affirming the April 26, 1996, Opinion and Order of the United States District Court for the Middle District of Pennsylvania (App. 6a).

Other relevant opinions and orders are as follows: September 20, 1995, Order of District Court (App. 29a); September 5, 1995, Memorandum and Order of District Court (App. 32a); two February 16, 1995, Memoranda and Orders of District Court (App. 52a, App. 55a); October 4, 1993, Opinion of the Court of Appeals for the Third Circuit, 6 F.3d 131 (App. 76a); June 2, 1992, Memorandum and Order of District Court (App. 108a); and April 16, 1992, Memorandum and Order of District Court (App. 111a).

STATEMENT OF JURISDICTION

The judgment of the United States Court of Appeals for the Third Circuit denying the Smiths' Petition for Rehearing was entered on May 14, 1997. Jurisdiction in this Court is invoked under 28 U.S.C. 1254(1).

STATUTORY PROVISION INVOLVED

The claims involved in this case arise under the Employee Retirement Income Security Act (ERISA), 29 U.S.C. §1001, *et seq.*

STATEMENT OF THE CASE

A. Facts

On August 27, 1985, Petitioner Nancy Smith suffered a cerebral hemorrhage. At that time, Mrs. Smith was employed as a nurse's aide for the Rehab Hospital in Mechanicsburg, Pennsylvania.[1] As a result of the cerebral hemorrhage, Mrs. Smith required round-the-clock skilled nursing care, and she became a patient at Seidle Memorial Hospital, a skilled nursing facility (App. 78a).

At the time of her hemorrhage, Mrs. Smith was covered under the Rehab Hospital's group health policy with Capital Blue Cross and Pennsylvania Blue Shield (App. 78a). That policy provided skilled nursing care up to a maximum lifetime benefit of one million dollars, and did not contain a limitation on the specific number of days that would be covered (App. 78a).

On December 1, 1986, while Mrs. Smith was still receiving skilled nursing care at Seidle Memorial, the Rehab Hospital's parent company, Respondent herein, directed its subsidiary hospitals to switch their health care coverage to self-funded insurance plans. Accordingly, the Rehab Hospital replaced the Blue Cross/Blue Shield policy in effect at the time of Mrs. Smith's cerebral hemorrhage with a self-funded plan entitled the P.I.A. Voluntary Employees Beneficiary Associate Plan (the "VEBA Plan") (App. 78a). Unlike the Blue Cross/Blue Shield policy, however, the VEBA Plan did not provide for

[1] Rehab Hospital in Mechanicsburg is the trade name for Respondent Pennsylvania Health Corporation.

unlimited skilled nursing care, but rather it covered only the first 180 days of an employee's confinement.

Employees of the Rehab Hospital received only one week's notice as to the change in plans. To aid employees in making this decision, Beverly North, Director of Personnel for Rehab Hospital, conducted seminars at which was distributed a document entitled "Transition Provision." (App. 78a)[2] This document summarizes the effects of the change of plans and provided in relevant part:

> WE WILL WAIVE OUR PRE-EXISTING CONDITION LIMIT FOR EVERYONE ENROLLED IN YOUR PRIOR PLAN AS OF 11/31/86
>
> °°°
>
> IF YOU OR YOUR DEPENDENTS ARE IN THE HOSPITAL OR DISABLED ON 12/1/86, BENEFIT PAYMENTS WILL BE THOSE OF YOUR PRIOR PLAN OR OUR PLAN, WHICHEVER IS LESS
>
> IF YOU ARE CURRENTLY DISABLED AND RECEIVING BENEFITS UNDER YOUR CURRENT CARRIER, BENEFITS WILL CONTINUE TO BE PAID TO YOU UNDER THE PROVISIONS OF THAT POLICY, NOT OURS

(App. 79a).

On behalf of his wife Nancy, Petitioner Joseph Smith attended two seminars conducted by Ms. North pertaining to the change in plans. Mr. Smith received a copy of the Transition Provision and was advised that benefits *would not change* under the VEBA Plan. After the seminar, Mr. Smith, concerned about his wife's benefits, specifically asked Ms. North what his wife's benefits would be under the VEBA Plan. Ms.

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[2] The actual document entitled "Transition Provision" is found in the Appendix at 135a.

North assured Mr. Smith that his wife would receive *exactly the same benefit under the VEBA Plan as under the Blue Cross/Blue Shield Policy in effect at the time of Mrs. Smith's cerebral hemorrhage.* Based on this assurance, Mr. Smith chose to enroll his wife in the VEBA Plan (App. 79a).

As the Smiths soon found out, the VEBA Plan did not provide the same benefit as the Blue Cross/Blue Shield policy in effect at the time of Nancy Smith's cerebral hemorrhage. In early 1987, just over a month after enrolling in the VEBA Plan, payments for Mrs. Smith's care were not forthcoming. Mr. Smith was assured, however, that the delays were totally administrative, secondary to the change in plans (App. 80a). On August 26, 1987, Mr. Smith received a letter from Hartford ITT, the VEBA Plan's claims processor, *denying payment for Mrs. Smith's care at Seidle citing the 180-day limit under the VEBA Plan* (App. 80a).

Mr. Smith appealed this initial decision but benefits were continually denied. The VEBA Plan did pay for skilled nursing care beyond the 180-day limit, but finally relied *only upon the 180-day provision* to deny reimbursement for skilled nursing care from April 8, 1988, to March 14, 1994.

There is no question that for the 20 months from August 26, 1986, to April 8, 1988, when Blue Cross/Blue Shield and VEBA reimbursed the Smiths for skilled nursing care and from April 8, 1988, to March 14, 1994, when VEBA denied payment, Mrs. Smith received the same care at the same Seidle facility for the same condition.

B. Procedural History

In July, 1990, the Smiths brought suit in the Court of Common Pleas of Cumberland County. The Defendants re-

moved the case to the Middle District of Pennsylvania because the Smiths' claim was subject to ERISA. The Smiths amended their complaint asserting ERISA liability under three theories: constitutionally protected breach of contract under §502(a)(1)(B), 29 U.S.C. §1132(a)(1)(B); equitable estoppel under §502(a)(3), 29 U.S.C. §1132(a)(3); and breach of fiduciary duty also under §502(a)(3). The District Court granted Defendants' Motion for Summary Judgment on all three theories.

The Third Circuit reversed the decision of the District Court in part and remanded *Smith v. Hartford Ins. Group*, 6 F.3d 131 (3d Cir. 1993) *(Smith I)*, holding that the Smiths be permitted to pursue the equitable estoppel and fiduciary duty theories.

On remand, the District Court bifurcated the issues of liability and damages. On February 16, 1995, the District Court decided the liability issue of equitable estoppel and fiduciary breach *in favor of the Smiths* (App. 55a). After the parties' unsuccessful attempts to amicably resolve the damage issue with a Magistrate Judge, the case returned to the District Court.

In September, 1995, the District Court held that the Smiths *were entitled to reimbursement* for past skilled nursing care and future skilled nursing care up to an amount of the Plan the Smiths could have converted to rather than enrolling in the VEBA Plan. The District Court in September, 1995, *also held that the Smiths were entitled to attorneys' fees and litigation expenses* (App. 50a-51a).

Although the only issues presented to the District Court over the five year litigation history were: (1) the Constitutional contractual "vesting" of the Blue Cross/Blue Shield plan with its $1,000,000 no 180-day limit; (2) equitable estoppel to purchase a $250,000 limit *substitute* policy; and (3) breach of fiduciary duty also under §502(a)(3) to purchase a *substitute*

policy, the District Court permitted belated defenses and immediate pre-trial expert testimony to assert an interpretation of the *substitute* policy in such a way as to exclude *any* coverage for *any* benefits if a person is *eligible* for Medicare even though Medicare does *not* and did not pay for skilled nursing care. The District Court also permitted the defense that, under the substitute policy, Mrs. Smith was not covered for skilled nursing care because she did not need skilled nursing care, even though Mrs. Smith fulfilled the contractual requirement of physician certification, skilled nursing services in a skilled nursing *facility* and actual payment until termination *based upon the 180-day limitation*. On these bases the District Court reversed its prior liability decision in favor of Plaintiffs. On the basis that the substitute insurance policy did not provide for attorneys' fees, the District Court also reversed its previous award of attorneys' fees to Plaintiffs' counsel.

The Smiths filed a timely appeal with the Third Circuit, which, without analysis or opinion, issued a judgment order affirming the District Court. The Smiths petitioned for rehearing en banc which was denied.

The Smiths now seek writ of certiorari from Your Honorable Court.

REASONS FOR ALLOWANCE OF THE WRIT

I. An Employer May Not *Constitutionally* Change The Medical Benefit Provisions Of An ERISA Plan Or Change Plans That Eliminate Or Reduce Contractually Mandated Benefits *After* An Employee Has Already Sustained A Catastrophic Disability And *Is Receiving Benefits At The Time Of The Change*

At the time of Mrs. Smith's debilitating stroke, she enjoyed, as part of the bargained-for exchange of her employment relationship, a compensation package that included health care coverage. *See generally, Commonwealth v. Walton,* 182 Pa. 373, 38 A. 790 (1897). The plan, provided by her employer, Respondent herein, included major medical coverage for expenses incurred for treatment in a skilled nursing facility up to a lifetime maximum benefit of $1,000,000. At the time of her debilitating stroke, Mrs. Smith's coverage was not limited in any way by a 180-day rule.

Following her cerebral hemorrhage and pursuant to the terms of the health insurance contract, Mrs. Smith's medical and rehabilitative expenses at a skilled nursing facility were paid by Blue Cross/Blue Shield. Mrs. Smith's skilled nursing care charges were paid from the date of her stroke, *August 27, 1985, until April 8, 1988,* first by Blue Cross/Blue Shield and then by VEBA, even though she was "eligible" for Medicare and even though VEBA contended that she did not need skilled nursing care after August 26, 1986. It is undisputed that Medicare would not, and did not, pay for skilled nursing care, and Mrs. Smith received the same care at the same facility by the same nurses from August 26, 1986, to March 14, 1994 (approximately eight years, two being reimbursed and six not).

Once Mrs. Smith had her stroke, she had a vested right to the medical benefits promised to her by Blue Cross/Blue Shield and by her employer. This point was eloquently summarized by Circuit Court Judge Hutchinson (now deceased) in his dissent in *Smith I*:

> I am unable to close this dissent, however, without commenting on the impact that termination of the Blue Cross/Blue Shield extended care benefit has on the Smiths and others like them. The feeling of unfairness is palpable. Hopefully, it will not be beyond the power of the courts and Congress to dispel that sense of injustice despite the limitations ERISA puts on the techniques the common law would employ to adjust rigid rules to particular situations. Logic may be the law's tool but its heart is justice, and the public's demand for concrete justice will not be contained by the straitjacket of inflexible rules. Thus, in any contract of insurance or indemnity, an insurer's ability to avoid performance after a risk becomes reality makes the promisor's covenant to indemnify the promisee against the risk illusory. Cf. Armistead v. Vernitron Corp., 944 F.2d 1287, 1296 (6th Cir. 1991) (absent clause in agreement permitting plan's termination, court would not read one into the agreement because to do so would render illusory the employer's promise to provide after retirement insurance benefits).
>
> An employer's promise to pay the cost of medical care for its employees is illusory if an employer can unilaterally eliminate or reduce benefits. The employer is then relieved of its promise of indemnity just when indemnity is most needed, and the employee in need of care is deprived of part of what he worked to get. For the employee, there is no *quid pro quo*. When benefits are thus reduced or snatched away, the promises those em-

> ployees thought their employers had made to them disappear. Some courts have, nevertheless, held that a self-insured employer can amend or terminate a benefits plan in a way that relieves an employer, in whole or in part, of its promise of indemnity to employees who have already suffered covered disabilities. See, e.g., McGann v. H & H Music Co., 946 F.2d 401 (5th Cir. 1991) (allowing employer, in ERISA §510 discrimination action, to reduce maximum welfare benefit for AIDS after participant became ill because ERISA does not vest rights in welfare benefit plans), cert. denied, U.S. , 113 S. Ct. 482, 121 L.Ed.2d 387 (1992); In re White Farm Equip. Co., 788 F.2d 1186, 1192-93 (6th Cir. 1986). The rationale of these decisions needs examination.
>
> •••
>
> The Smiths present a hard case. *It is regrettable that neither this Court nor the district court has been able to address directly the illusory promise issue that a restrictive change in an ERISA health care plan presents when a reduction in benefits incident to the adoption of a new plan is applied to disabled participants after they are already receiving benefits under the plan in existence when they became sick and disabled.*

Smith I, 6 F.3d 131, 146-147 (1993), Hutchinson, J., dissenting (emphasis added). (See also, App. 105a-107a.)

Following the *Smith I* remand, the trial court and a Third Circuit panel *had the opportunity* but opined that an employee's right to contractually guaranteed ERISA medical benefits are *not* constitutionally protected.

Under ordinary everyday contract principles, Mrs. Smith would be entitled to the benefits of her bargained-for contract rights that *existed at the time of her injury*. If this were not an

ERISA case, Blue Cross and Blue Shield would have been required to reimburse Mrs. Smith for treatment in a skilled nursing care facility up to a maximum lifetime benefit of $1,000,000 without any consideration of a particular number of days.

It is true that numerous federal courts have held that ERISA employee welfare benefit plans are excluded from the stringent minimum vesting, participation, and funding standards imposed on pension plans. Your Court, however, should not consider these decisions as established precedent that welfare benefit plans can *never* vest and should revisit Congressional intent in light of the contracts clause of the Constitution with respect to employee welfare benefit plans.

The Fourth Circuit in *Wheeler v. Dynamic Engineering, Inc.*, 62 F.3d 634 (4th Cir. 1995), *cert. denied,* U.S. and the Tenth Circuit in *Buell v. Security General Life Ins. Co.*, 987 F.2d 1467 (10th Cir. 1993), *cert. denied,* 510 U.S. 916 (1993) determined that, despite ERISA's exclusion of welfare benefit plans from vesting requirements, vesting could and does occur under welfare benefit plans at the point that an injury or illness *occurs*. Further, if an insurance policy insures against expenses, coverage vests when expenses are incurred. This makes sense. Generally, an employer can change the terms of an employment contract prospectively, but not retroactively. An employee can seek another job if the employer changes his/her hourly rate or medical benefits. This is not an option after the employee has put in his time or suffered a disabling injury.

As stated before, few of the numerous cases which hold that welfare benefits do not vest involved *situations where medical harm had already occurred and where the payment of benefits was ongoing* when the plan changed.

Traditionally, where a policy insures against illness, coverage for *all* medical costs arising from that illness vests *when* the illness occurs. *Wheeler, Buell, supra.*

Your Court denied certiorari in *McGann v. H & H Music Co.*, 946 F.2d 401 (5th Cir. 1991), *cert. denied,* 506 U.S. 981 (1992). There, an employer was permitted to alter the terms of an employee benefit plan to reduce coverage for AIDS-related illnesses from $1,000,000 to $5,000. That alteration was permitted even as to an employee who had acquired AIDS and submitted claims under the plan prior to the changes. Although *McGann* can be distinguished from the case at bar in that the employer in *McGann* did not deny coverage, it is intellectually more honest to assert that the Fifth Circuit was wrong. The *McGann* decision is contrary to a number of other decisions. *See,* more recent Circuit decisions in *Wheeler* where *Your Court also denied certiorari.* Also, *Buell, supra. See also, Conkwright v. Westinghouse Electric Corp.*, 933 F.2d 231 (4th Cir. 1991); *Dister v. Continental Group, Inc.*, 859 F. 2d 1108 (2d Cir. 1988); and *Kross v. Western Electric Co., Inc.*, 701 F.2d 1238 (7th Cir. 1983).

Nancy Smith was covered under a health insurance policy sponsored by her employer. Coverage under the plan was triggered at the time she suffered the cerebral hemorrhage. It follows that coverage for that illness vested at that time. To hold otherwise would violate reasonable expectations, constitutional rights, and inherent, established concepts of justice.

The trial court initially found in favor of the Plaintiffs on estoppel and fiduciary grounds while denying Plaintiffs' Constitutional grounds. At trial, however, the trial court found for the Defendant on the basis that the stipulated *substitute* policy had a Medicare exclusion, and Mrs. Smith was "eligible" for Medicare. The trial court erroneously held that the Medicare exclusion applied even though skilled nursing care would not

and was not paid by Medicare. The trial court also misinterpreted the substitute policy by permitting defense expert testimony to opine that Mrs. Smith did not need skilled nursing care even though the substitute policy merely required that the treating physician certify a need for skilled nursing care in a skilled nursing care facility. The certification continued until Defendant denied coverage based upon the 180-day limitation. Based upon the denial of coverage, it would have been senseless to certify Mrs. Smith's need to a carrier which refused to pay. The treating physician did certify Mrs. Smith's need for intermediate care which was the equivalent to skilled nursing care for public assistance.

Although the trial court was in error in its narrow interpretation of the Medicare exclusion, the Constitutional issue is the one of national importance.

Both the United States Constitution and the Pennsylvania Constitution prohibit the impairment of the obligation of contracts. U.S. Const. Art. I, Sec. 10, C1.1; Pa. Const. Art. 7, Sec. 17.

In his dissent in *Smith I*, Judge Hutchinson stated that the application and/or interpretation of the provisions of ERISA to an employee receiving benefits at the time impaired the existing contractual rights of the parties such that a substantial injustice has occurred. The application/interpretation of the ERISA provisions in this case has worked a substantial injustice by eroding a basic tenet of our society, i.e., the right of individuals to enter contractual relationships and be bound thereby.

Recognizing the importance of contracts and contractual rights, the framers of our state and federal constitutions included provisions that forbade states from legislatively impairing the obligations of contracting parties. Why then should the

application/interpretation of a statute that has the same practical effect not be similarly disfavored?

In contract clause cases, Your Court has recognized three components to the inquiry whether there has been an impairment of a contractual obligation. Where a change in the law substantially impairs a contract, the contract clause is at issue. *Allied Structural Steel Co. v. Spannaus,* 438 U.S. 234, 244 (1978). The same analysis should apply where the application/interpretation of a statute impairs the existing contractual relationship of private contracting parties. Constitutionally, legislatively, contractually, legally it should make no difference that we are dealing with health benefits rather than other contract rights.

ERISA was enacted to *protect* "the interests of participants in employee benefit plans and their beneficiaries." 29 U.S.C. §1001(b). Judicial decisions to the contrary have precisely the *opposite* effect. Courts that interpret ERISA in such a manner as to permit employers to terminate an employee's right to promised benefits at will and to deprive employees of any recourse for such action provide employers with a loophole through which they can escape their contractual responsibilities. If an employer has a self-funded plan and an employee sustains a catastrophic injury, the employer need only change the plan to avoid his contractually mandated duties. One day there is an exclusion for AIDS, the next for transplants, the next for skilled nursing care beyond 180 days or a medical limitation of $5,000 instead of $1,000,000.

Working men and women rightfully view employer-provided health care benefits as a vital part of their compensation packages. For some employees, health benefits may be more important than wages, and may serve as an inducement to accept employment. Medical coverage for health care has

been a continuous subject of executive and legislative debate over the last five years.

Judicial decisions that abrogate these important employee considerations have rendered illusory any promise or obligation on the part of an employer to provide such benefits. Under the current state of the law, an employer's promise to provide health care benefits is a promise only for a moment. This substantial injustice compels review by Your Honorable Court.

II. A Plaintiff Is Entitled To Attorneys' Fees Under ERISA Regardless Of Whether Or Not The Plaintiff Was A "Prevailing Party," Where The Plaintiff Conducted Seven Years Of Complex Litigation That Served To Advance The Law Or, In The Alternative, Where The Plaintiff Was The Prevailing Party But Was Awarded No Damages Or, Alternatively, Where The Trial Court Under *Appropriate* Legal Bases Held That Plaintiff Was Entitled To Attorneys' Fees But Later Reversed Its Position On The *Improper* Basis That The Substitute Insurance Policy Did Not Provide For Attorneys' Fees

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At oral argument before the Third Circuit, the panel recognized the error of the trial court on the attorneys' fees issue (denying attorneys' fees because not provided in the substitute insurance policy), but failed to remand for reconsideration, briefing, and/or argument. Instead, the Third Circuit panel raised the issue of a zero damage award and concluded that such an award provided an alternative, legally justifiable basis for upholding the trial court. This issue of zero damages, i.e., "prevailing party" was never briefed or even

mentioned in this case, but only arose at the suggestion of one of the Circuit Court panel members.

This "zero damages" issue is essentially a question of whether the party seeking attorneys' fees was the "prevailing party." Most fee shifting statutes authorize that a court may award fees and costs to the successful or prevailing party in the action. *See generally,* Civil Rights Act of 1964 (Title VII), 42 U.S.C. §1983, §2000e-5(k); Copyright Act of 1976, 17 U.S.C. §505; Equal Access to Justice Act, 28 U.S.C. §2412; and Clean Water Act, 33 U.S.C. §1251.

This is *not so with the ERISA fee shifting provisions.* Section 502(g) of ERISA provides for an award of attorneys' fees to *either party.* Had Congress intended that only the prevailing party be entitled to an award of fees and costs, it could have easily provided for that. That it did not in light of other statutes with fee shifting provisions clearly indicates there was no intent to require success in awarding attorneys' fees in ERISA litigation.

Your Court has never had the occasion to rule in this area, but because of a split among the circuits, Your review is required.

The Second Circuit has held that Section 502(g) contains no requirement that the party awarded attorneys' fees be the prevailing party. *Miller v. United Welfare Fund,* 72 F.3d 1066 (2d Cir. 1995). Neither has the Ninth Circuit relied on the prevailing party doctrine. *Sokol v. Bernstein,* 812 F.2d 559 (9th Cir. 1987); *Hummell v. S.E. Rykoff & Co.,* 634 F.2d 446 (9th Cir. 1980).

The Ninth Circuit has relied on several factors, none of which require that the requesting party be the prevailing party. Specifically, one of the factors is extremely significant to the case at bar. The Ninth Circuit has said that a district court should consider, among other things:

> [w]hether the parties requesting fees sought to benefit all participants and beneficiaries of an ERISA plan *or to resolve a significant legal question regarding ERISA* ...

Hummell, supra at 453 (emphasis supplied). *See also, Dodson v. Woodmen of the World Life Ins. Society,* 109 F.3d 436 (8th Cir. 1997); *Lawrence v. Westerhaus,* 749 F.2d 494 (8th Cir. 1984).

Conversely, the Seventh Circuit has held that the ERISA fee shifting provision requires the requesting party be the prevailing party in ERISA litigation. *Hooper v. Demco, Inc.,* 37 F.3d 287 (7th Cir. 1994).

In this case, the Third Circuit held that the Petitioners were not entitled to attorneys' fees and expenses despite Plaintiffs having conducted *seven years of complex litigation* which served to advance the law and a finding by the District Court that Plaintiffs *had met all of the factors set forth by Ursic v. Bethlehem Mines,* 719 F.2d 670 (3d Cir. 1983).

Your Court should grant certiorari in order to clarify the disparity between the circuits and determine whether or not the prevailing party doctrine is applicable to ERISA Section 502(g) litigation.

In any event, Petitioners in this case were the prevailing party. In its February 16, 1995, Memorandum and Order, the District Court held:

> Judgment is granted in favor of Plaintiffs on the liability aspects of their equitable estoppel and breach of fiduciary claims against Defendant Pennsylvania Health Corporation d/b/a the Rehab Hospital of Mechanicsburg.

(App. 55a).

Moreover, in its September 5, 1995, Memorandum and Order, the District Court held:

> (1) Plaintiffs are entitled to reimbursement for past skilled nursing care and other medical and rehabilitative expenses, and coverage for future skilled nursing care and other medical and rehabilitative expenses, up to the amount of the individual Blue Cross/Blue Shield policy that Nancy Smith could have converted to rather than enrolling in Defendant's new VEBA plan;
>
> ∘∘∘
>
> (3) Plaintiffs are entitled to an award of attorneys' fees and expenses;
>
> ∘∘∘

September 5, 1995, Memorandum and Order, App. at 50a-51a.

Despite this, in April, 1996, the very same District Court held in effect that Plaintiffs were entitled to zero damages:

> Under the terms of the BC/BS policy to which Nancy Smith could have converted at the time that she elected to enroll in the VEBA plan, Plaintiffs are not entitled to any reimbursement for services provided to Nancy Smith from September 1986 through March 1994[.]

April 26, 1996, Opinion and Order, App. at 28a.

Moreover, the reason cited by the District Court for failing to award attorneys' fees, in relevant part, was:

> Charges for attorney's fees would not have been covered under the BC/BS policy to which Nancy Smith could have converted.

(App. 27a).

Clearly, the wrong analysis was employed. ERISA Section 502(g), 29 U.S.C. §1132(g) allows for an award of attorneys'

fees and legal expenses. Statutes similar to ERISA that allow for attorneys' fees are designed to provide access to judicial relief for statutory violations by providing a fee incentive for lawyers to represent persons injured by violations of these statutes.

In fashioning its September 5, 1995, decision, the District Court used the factors set down by the Third Circuit in *Ursic v. Bethlehem Mines, supra*. *Ursic* was based on the Ninth Circuit decision of *Hummell v. S.E. Rykoff & Co., supra*. *See also, Anthuis v. Colt Industries Operating Corp.*, 971 F.2d 999 (3d Cir. 1992). The District Court thoroughly analyzed each of the factors as applied to the case and ultimately found that the Smiths were entitled to attorneys' fees under ERISA. Less than eight months later, the District Court completely reversed itself.

The right of a plaintiff to receive attorneys' fees and legal expenses is governed by ERISA and judicial precedent pertaining to same. *It is not governed by individual policies.* If it were, what kind of right would it be? Surely no insurer would write a policy that conveyed such a right. That is precisely why other legal principles and statutes control. When there is a split of authority in the Circuits on the proper standard to award attorneys' fees, Your Court should grant certiorari.

CONCLUSION

The Third Circuit abdicated its responsibility to correct the District Court's errors. It provided no discussion or analysis. The two issues presented are very important, and the state of the law uncertain. ERISA welfare plans involving medical benefits and the medical insurance area generally are top priorities and concerns of the Congressional and Executive branches of the government, and of the citizens of the United States of America.

Respectfully submitted,
ANGINO & ROVNER, P.C.
RICHARD C. ANGINO
I.D. No. 07140
Attorneys for Petitioners

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

Nos. 96-7297 and 96-7328

NANCY M. SMITH; JOSEPH L. SMITH,
her husband, *Appellants/Cross-Appellees,*

vs.

THE HARTFORD INSURANCE GROUP; THE PROVIDENT LIFE AND ACCIDENT INSURANCE GROUP; NATIONAL MEDICAL ENTERPRISES, INC.; NATIONAL MEDICAL SPECIALTY HOSPITAL GROUP; PSYCHIATRIC INSTITUTES OF AMERICA HEALTH CARE GROUP; PENNSYLVANIA HEALTH CORP., d/b/a The Rehab Hospital in Mechanicsburg; P.I.A. VOLUNTARY EMPLOYEES BENEFICIARY ASSOCIATION GROUP INSURANCE PLAN; P.I.A. VOLUNTARY EMPLOYEES BENEFICIARY ASSOCIATION ADMINISTRATIVE COMMITTEE

Pennsylvania Health Corp., d/b/a The Rehab Hospital of Mechanicsburg, *Appellee/Cross-Appellant*

SUR PETITION FOR REHEARING

PRESENT: BECKER, STAPLETON, MANSMANN, GREENBERG, SCIRICA, COWEN, NYGAARD, ALITO, ROTH, LEWIS, and McKEE, *Circuit Judges,* and DUPLANTIER,* *District Judge.*

The petition for rehearing filed by the appellants/cross-appellees, Nancy M. Smith and Joseph L. Smith, in the above-entitled case having been submitted to the judges who partici-

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* Honorable Adrian G. Duplantier, United States District Judge for the Eastern District of Louisiana, sitting by designation, whose vote is limited to panel rehearing only.

pated in the decision of this court and to all other available circuit judges in regular active service, and no judge who concurred in the decision having asked for rehearing, and a majority of the circuit judges in regular active service not having voted for rehearing by the court in banc, the petition for rehearing is denied.

BY THE COURT,
/s/Timothy K. Lewis
Circuit Judge

Date: MAY 14 1997

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

April 15, 1997
No. 96-7297 and 96-7328
Nancy Smith, et. al.
v.
The Hartford Insurance Group, et. al.
(Middle District of Pennsylvania (Harrisburg)
Civil No. 90-cv-01541) (SHR)
Present: Lewis, *Circuit Judge*

1. Motion by Appellants/Cross Appellees to file exhibits A, B, and D through I attached to petition for rehearing in banc and appendix to petition for rehearing.

2. Petition for Rehearing with exhibits attached and appendix to petition for rehearing submitted to court for disposition on 4/15/97.

3. Any response to the above motion due 4/25/97 will be forwarded upon receipt.

Christina T. Cook
Case Manager (215) 597-1896

ORDER

The foregoing motion is denied.

By the Court,
/s/Timothy K. Lewis
Circuit Judge

Dated: May 14, 1997

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

Nos. 96-7297 and 96-7328

NANCY M. SMITH; JOSEPH L. SMITH,
Her Husband, *Appellants/Cross Appellees,*

v.

THE HARTFORD INSURANCE GROUP; THE PROVIDENT LIFE AND ACCIDENT INSURANCE GROUP; NATIONAL MEDICAL ENTERPRISES, INC.; NATIONAL MEDICAL SPECIALTY HOSPITAL GROUP; PSYCHIATRIC INSTITUTES OF AMERICA HEALTH CARE GROUP; PENNSYLVANIA HEALTH CORP., d/b/a The Rehab Hospital in Mechanicsburg; P.I.A. VOLUNTARY EMPLOYEES BENEFICIARY ASSOCIATION GROUP INSURANCE PLAN; P.I.A. VOLUNTARY EMPLOYEES BENEFICIARY ASSOCIATION ADMINISTRATIVE COMMITTEE

Pennsylvania Health Corp., d/b/a The Rehab Hospital of Mechanicsburg, *Appellee/Cross Appellant.*

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

(D.C. Civil No. 90-01541)

District Judge: Honorable Sylvia H. Rambo

ARGUED March 11, 1997

BEFORE: MANSMANN, LEWIS, *Circuit Judges,* and DUPLANTIER,* *District Judge.*

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* The Honorable Adrian G. Duplantier, Senior United States District Judge for the Eastern District of Louisiana, sitting by designation.

JUDGMENT ORDER

After consideration of all contentions raised by the appellants and cross-appellants, it is

ADJUDGED AND ORDERED that the judgment of the district court entered on April 29, 1996, be and is hereby *AFFIRMED*.

Each party to bear its own costs.

BY THE COURT:
/s/Timothy K. Lewis
Circuit Judge

Attest:
/s/Illegible
Chief Deputy Clerk
Date: Mar 28 1997

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF PENNSYLVANIA

NANCY M. SMITH and JOSEPH L. SMITH,
Her Husband, Plaintiffs

v.

PENNSYLVANIA HEALTH CORP., d/b/a THE REHAB HOSPITAL OF MECHANICSBURG,

JUDGMENT IN A CIVIL CASE

CASE NUMBER: 1:CV-90-1541; J. Rambo

☐ *Jury Verdict.* This action came before the Court for a trial by jury. The issues have been tried and the jury has rendered its verdict.

☒ *Decision by Court.* This action came to trial or hearing before the Court. The issues have been tried or heard and a decision has been rendered.

IT IS ORDERED AND ADJUDGED that judgment be and is hereby entered in favor of Defendant Pennsylvania Health Corp., d/b/a The Rehab Hospital of Mechanicsburg and against plaintiffs, Nancy M. Smith and Joseph L. Smith, Her Husband.

Date: April 26, 1996

Mary E. D'Andrea, Clerk

(By) /s/George T. Gardner, Deputy Clerk

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

CIVIL ACTION NO. 1:CV-90-1541

NANCY M. SMITH and JOSEPH L. SMITH,
Her Husband, Plaintiffs

v.

PENNSYLVANIA HEALTH CORP., d/b/a THE REHAB HOSPITAL OF MECHANICSBURG, Defendant

FINDINGS OF FACT AND CONCLUSIONS OF LAW

I. Introduction—Procedural Posture

On January 17, 1996, the court conducted a one-day non-jury trial in the captioned matter—the final stage in this case that has been pending before the court since 1990. The court had previously resolved by order almost all of the issues in the case.[1] In its February 16, 1996, memorandum and order, the court concluded that Defendant was liable to Plaintiffs under the Employment Retirement Security Income [sic] Act (ERISA) on theories of fiduciary duty and equitable estoppel. In its memorandum and order dated September 5, 1995, the court held that Plaintiff Nancy Smith's recoverable damages were limited to:

> reimbursement for past skilled nursing care and other medical and rehabilitative expenses, and coverage for future skilled nursing care and other medical and rehabilitative expenses, up to the limit of the individual [Blue

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[1] The court's orders of February 16, 1995, and September 5, 1995, provide the background of the case and the court will not attempt in this memorandum to undertake yet another accounting of its factual history. Only the facts relevant to the issues addressed at trial will be recited.

> Cross/Blue Shield (BC/BS)] policy that Nancy Smith could have converted to when she changed to Defendant's new [Voluntary Employees Beneficiary Association Group Insurance (VEBA)] plan.

Nancy Smith v. Pennsylvania Health Corp., No. 90-1541, slip op. at 23 (M.D. Pa. Sept. 5, 1995).[2] The court further clarified the remaining issues in the case in its order dated September 20, 1995:

> At the September 8, 1995, conference, counsel . . . discussed the treatment Nancy Smith would have obtained had she been covered by a . . . . [BC/BS] individual subscriber policy, and whether she is entitled to reimbursement for treatment that she had to forego in the absence of such coverage. The parties apparently misunderstand the court's ruling on appropriate reimbursement. Reimbursement will be made for funds actually expended or owed for treatment actually received by Nancy Smith, *if* such treatment was covered by the individual BC/BS policy that she could have converted to when she elected to join the VEBA plan. To rule on such reimbursement, the court must be apprised of: (1) the extent of coverage Nancy would have received under the

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[2] In its September 5, 1995, memorandum, the court also addressed Defendant's motion for reconsideration of the court's February 16, 1995, order:

> The final order awarding the remedy will be entered after the court and/or the parties resolve the factual disputes pertinent to the policy, the covered incurred expenses to date, the amounts paid by the VEBA plan already, and any other pertinent factual matters . . . . Defendant's motion for reconsideration will be granted, but the court will await to correct the factual findings referenced in the motion until it makes the ultimate factual findings on the remedy.

Id. Defendant acknowledged in its pretrial memorandum that the court's order of September 5, 1995, and the parties' stipulations have resolved the issues raised with respect to the challenged findings. The court has incorporated the parties' stipulations in its findings of fact.

> BC/BS policy she could have converted to when she elected to join the VEBA plan; (2) the treatment actually received by Nancy that would have been covered by such individual policy, and the amounts expended or owed for such treatment and services; (3) the party or parties to whom reimbursement must be made for such covered treatment; and (4) the extent of coverage that remains available to Nancy after reimbursement, given any coverage limitations in the policy. Assuming there is unused coverage of any type, Nancy will not be reimbursed for services or treatment she could have received but did not, but all remaining coverage will be made available to her.

Nancy Smith v. Pennsylvania Health Corp., No. 90-1541, slip op. at 2 (M.D. Pa. Sept. 20, 1995) (emphasis in original). On November 15, 1995, the parties submitted a status report to the court stating that they had stipulated to the BC/BS policy that Nancy Smith could have applied to at the time that she elected to enroll in the VEBA plan. The policy to which the parties stipulated provided a lifetime maximum benefit of $250,000. This memorandum sets forth the court's findings of fact and conclusions of law as a result of the trial held on January 17, 1996, with regard to the amount of reimbursement due to Plaintiffs.

II. Findings of Fact

A. *History of Hospitalizations*

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(1) On August 27, 1985, Plaintiff Nancy Smith suffered a cerebral hemorrhage and was admitted to Holy Spirit Hospital.

(2) Nancy Smith's cerebral hemorrhage rendered her disabled in that she was and remains unable to work or care for herself.

(3) On October 10, 1985, Nancy Smith was transferred to Camp Hill Nursing Home where she received skilled nursing care.

(4) On October 21, 1985, Nancy was transferred to Seidle Memorial Hospital's subacute nursing facility.

(5) On December 26, 1985, Nancy was admitted to the Mechanicsburg Rehab Hospital.

(6) At the time of her admission to the Rehab Hospital, Nancy was nonverbal and required total assistance with all activities of daily living, although she did have some movement in her right upper and lower extremities.

(7) Except for a short period of time when she was admitted to Holy Spirit Hospital from January 8, 1986, through January 21, 1986, for the insertion of a V-P shunt, Nancy Smith remained at the Rehab Hospital until August 1, 1986.

(8) On August 1, 1986, Nancy Smith was discharged to her home with her husband, Joseph Smith, until a bed at Seidle became available to her.

(9) On August 26, 1986, Nancy was readmitted to Seidle Memorial Hospital.

(10) Nancy remained at Seidle until March 14, 1994, when she was discharged to the Pennsylvania State College of Medicine Milton S. Hershey Medical Center for aggressive rehabilitation therapy.

(11) On August 26, 1994, Nancy Smith was readmitted to Seidle Memorial Hospital.

(12) On September 19, 1994, Nancy was discharged to her home where she currently resides.

Appendix

B. *Level of Care and Services Received*

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(13) The decision regarding what level of care a patient at Seidle is to receive is made by Seidle's Utilization Review Committee, which is comprised of physicians.

(14) At the time of her admission to Seidle in August of 1986, Nancy Smith was certified by her attending physician as requiring skilled nursing care.

(15) While at Seidle, from October 10, 1986, until April 8, 1988, Nancy was recertified on a monthly basis by Seidle's Utilization Review Committee as being in need of skilled care.

(16) From April 8, 1988, until April 14, 1989, Nancy Smith's medical records from Seidle do not reflect the level of care she was certified for.

(17) On April 14, 1989, Nancy's medical records from Seidle show that she was recertified for intermediate care.

(18) Nancy was certified by Seidle as requiring intermediate care from April of 1989 until the time of her final discharge in September of 1994.

(19) Nancy Smith received physical therapy at Seidle from August 1986 until the time of her discharge in 1994.

(20) As of September 3, 1986, Nancy Smith was at a maintenance stage for physical therapy.

(21) On May 15, 1989, Seidle advised Joseph Smith that the Utilization Review Committee had determined that under applicable Medicare and Blue Cross standards, Nancy was no longer eligible to continue to receive physical therapy.

(22) Joseph Smith was advised that as of May 15, 1989, he could continue physical therapy for Nancy on a private pay basis.

(23) After May 15, 1989, Joseph Smith continued to provide physical therapy services to his wife until the end of her residency at Seidle.

C. *History of Insurance Coverage*

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(24) At the time of her disabling hemorrhage, Nancy Smith was a beneficiary of Rehab's group health care policy with Capitol [sic] BC/BS.

(25) BC/BS paid for Nancy Smith's skilled nursing care at Seidle until December 1986.

(26) On December 6, 1986, Joseph Smith chose to enroll Nancy in the VEBA plan.

(27) From December 6, 1986, until April 7, 1988, VEBA paid for the skilled nursing care provided to Nancy at Seidle.

(28) After VEBA stopped payments, Nancy Smith's continuing maintenance reverted to Medicaid.

(29) On June 30, 1988, Medicare became Nancy Smith's primary payor.

(30) At the time that Medicare payments commenced on June 30, 1988, Nancy Smith could have converted to a supplemental BC/BS plan, which would have co-paid with Medicare for inpatient skilled nursing care.

D. *Coverage Available Under the Applicable BC/BS Policy*

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(31) The BC/BS agreements to which Nancy Smith could have converted at the time that she enrolled in the VEBA plan contained the following relevant definitions:

(a) *Covered service*—a service or supply in this contract for which benefits will be provided when rendered by the provider.

(b) *Custodial care*—care provided primarily for the maintenance of the subscriber which is designed essentially to assist the subscriber in meeting the activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury or condition. Custodial care includes but is not limited to help in walking, bathing, dressing and feeding, preparation of special diets, supervision over self-administration of medication, and other services that can be provided by non-medical personnel.

(c) *Medically necessary*—services or supplies provided by a provider that the plan determines are:

(i) appropriate for the symptoms and diagnosis or treatment of the subscriber's condition, illness, disease, or injury; and

(ii) provided for the diagnosis, or the direct care and treatment of the subscriber's condition, illness, disease, or injury; and

(iii) in accordance with standards of good medical practice; and

(iv) not primarily for the convenience of the subscriber or the provider; and

(v) the most appropriate supply or level of service that can safely be provided to the subscriber. When applied to hospitalization, this further means that the subscriber requires acute care as a bed patient due to the nature of the services provided or the subscriber's condition, and

the subscriber cannot receive safe or adequate case [sic] as an outpatient or in another less costly setting.

(d) *Subscriber*—the contract holder, and if applicable, the contract holder's dependents. A subscriber does not include any person who is eligible for medicare.

(e) *Medicare*—the programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

(f) *Inpatient*—a subscriber who is treated as a registered bed patient in a facility provider, who is expected to stay overnight and for whom a room and board charge is made.

(g) *Provider*—a person or entity licensed or approved to provide covered services and performing such services within the scope of such licensure. Providers include facility providers such as skilled nursing facilities and professional providers including doctors, licensed practical nurses, and physical therapists.

(h) *Participating Provider*—a provider that has an agreement with the plan pertaining to payment for covered services rendered to a subscriber.

(i) *Skilled nursing facility*—a facility provider approved by the plan which is primarily engaged in providing skilled nursing and related services on an inpatient basis to patients requiring twenty-four hour skilled nursing services but not requiring confinement in an acute care hospital. Such care is rendered by or under the supervision of physicians. A skilled nursing facility is not, other than incidentally, a place that provides:

(i) minimal care, custodial care, ambulatory care, or part-time care services; or

(ii) care or treatment of mental illness, alcoholism, drug abuse or pulmonary tuberculosis.

(32) The BC/BS policy to which Nancy Smith could have converted at the time that she chose to enroll in the VEBA plan included the following relevant benefit provisions:

(a) *Level of payments*—payments under the major medical program are generally made on the basis of 80% of eligible expenses. The amounts remaining unpaid for covered services under the basic plans after benefits have been provided under such plans are eligible major medical expenses except that benefits will not be provided for charges in excess of the provider's reasonable charges.

(b) *Lifetime maximum*—the overall maximum amount of payments for each subscriber under the major medical program may not exceed $250,000 during his/her lifetime.

(c) *Benefit period and deductible*—benefits under the major medical program are provided on a calendar year basis. In each calendar year, the subscriber must satisfy the $250 deductible.

(33) The BC/BS policy to which Nancy Smith could have converted at the time that she elected to enroll in the VEBA plan provides that the following are covered services:

(a) *Bed, board and general nursing services*—bed, board and nursing services in a hospital or other facility provider when a subscriber occupies:

(i) a room with two or more beds;

(ii) a private room if it is medically necessary;

(iii) a bed in a special care unit.

(b) *Ancillary Services*—services and supplies which are regularly provided and billed by a participating

provider for use during the inpatient stay, including but not limited to:

(i) prescribed drugs—drugs and medicine provided to a subscriber who is an inpatient in a facility provider.

(ii) diagnostic services—services ordered by a professional provider because of specific symptoms to determine a definite condition or disease, including all medically accepted diagnostic services.

(iii) therapy services—services or supplies ordered by a professional provider used for the treatment of an illness or injury, including: physical therapy, occupational therapy, speech therapy.

(c) *Skilled nursing facility services*—skilled nursing services in semi-private accommodations in a skilled nursing facility if the plan has received from the attending physician a statement that continued skilled nursing care in a skilled nursing facility is medically necessary. To be a covered service, the plan must concur with the physician's certification that the care is medically necessary.

(34) The BC/BS policy to which Nancy Smith could have converted at the time that she enrolled in the VEBA plan contained the following limitations and exclusions:

(a) *Exclusions*—except as specifically provided in this contract, no benefits will be provided for services, supplies or charges:

(i) which are not medically necessary as determined by the plan;

(ii) rendered by a provider who is a member of the subscriber's immediate family;

(iii) for personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment;

(iv) for custodial care, domiciliary care or rest cures;

(v) for dental surgery, dentistry or dental processes except as specifically stated;

(vi) for eyeglasses, contact lenses, or vision examinations for prescribing or fitting eyeglasses or contact lenses;

(vii) to the extent that payment has been made under Medicare or would have been made if the subscriber had applied for Medicare and claimed Medicare benefits.

(35) The BC/BS policy to which Nancy Smith could have converted at the time that she elected to enroll in the VEBA plan included a clause providing for the termination of a subscriber's coverage "[w]hen a Subscriber becomes eligible for enrollment under the Medicare Program (Title XVIII of the Social Security Act), he or she will no longer be eligible to remain a Subscriber under this Contract but may convert to other available programs for Medicare eligible Subscribers."

(36) The BC/BS policy to which Nancy Smith could have converted at the time that she enrolled in the VEBA plan contained a conversion provision which provided: If an individual ceases to be a subscriber under this contract, the individual is eligible for coverage under a conversion contract then available from the plan. The coverage may be different from the coverage provided under this contract.

III. Discussion

A. *Defendant's Affirmative Defenses*

In their pretrial memorandum, Plaintiffs sought to bar Defendant from asserting various "affirmative defenses" at trial, arguing that Defendant was precluded from asserting such defenses because it had not raised them in either its answer to Plaintiffs' complaint or its answer to Plaintiffs' second amended complaint. Defendant has raised as a defense to Plaintiffs' claim for damages the following arguments: (1) that Nancy Smith has not required skilled nursing care since August 1, 1986, (2) that the care provided to Nancy Smith was not medically necessary and/or appropriate for the treatment of her condition, and (3) that when Nancy Smith became eligible for Medicare as a disabled beneficiary under Social Security after the initial twenty-four months of her disability, any medical services rendered thereafter would have been excluded from coverage under the applicable BC/BS plan.

First, Defendant did assert the affirmative defense that Nancy Smith has not required skilled nursing care since August 1, 1986, in its answers to Plaintiffs' first and second amended complaints. Second, the court questions whether the defenses asserted by Defendant are correctly characterized as affirmative defenses. Plaintiffs have the burden of proving damages in this case and proving damages would necessarily encompass disproving the issues Defendant has raised.

Third, while it is usually true that the failure to plead an affirmative defense in accordance with Federal Rule of Civil Procedure Rule 8 (c) results in its waiver, that is not true in the instant case. "The failure to plead an affirmative defense does not constitute a waiver if that defense was not available to the party at the time its pleading was filed." James W. Moore,

Federal Practice ¶8.27[3], at 174 (1995). *See also EEOC v. United States Steel Corp.*, 921 F.2d 489, 491 n.2 (3d Cir. 1990) (citations omitted). Plaintiffs and Defendant did not stipulate to the applicable BC/BS policy to which Nancy Smith could have converted until November 15, 1995, when they filed their joint stipulation with the court. The defenses that Defendant sought to raise at trial on the issue of damages arise from the policy to which the parties only recently stipulated. Two of these defenses, which are based on the language in the policy, were unavailable to Defendant at the time when it answered both Plaintiffs' original and amended complaints. Thus, the court finds that Defendant is not barred from asserting these defenses to Plaintiffs' claim for damages at this juncture in the case.

B. *Defendant's Objections to Plaintiffs' Expert's Testimony*

At trial, the court reserved decision regarding Defendant's objections to certain portions of Plaintiffs' expert Jane Mattson's, Ph.D., testimony. Defendant objected to Ms. Mattson's testimony regarding whether services provided to Nancy Smith were medically necessary within the definition of "medically necessary services" contained in the applicable BC/BS agreements. Defendant argued that Ms. Mattson, an occupational therapist, was not qualified to express an opinion regarding these issues. The court will sustain Defendant's objection as to Ms. Mattson's qualifications to testify in this regard. The court will also sustain Defendant's objection to Ms. Mattson's testimony regarding pages 4-5 of her rebuttal report dated November 29, 1995. (Pls.' Ex. 36.) The court finds that Ms. Mattson is not qualified to testify to whether or not Nancy Smith would have obtained a doctor's prescription for her motorized wheelchair and hospital bed.

The court will overrule Defendant's remaining objections.

The court notes that the majority of the evidence presented by Plaintiffs at trial on the issue of the appropriate amount of reimbursement due to Plaintiffs is irrelevant to the court's inquiry regarding this issue. As discussed *supra* at pp. 1-3, in its order dated September 20, 1995, the court clearly stated that its inquiry into the appropriate amount of reimbursement due to Plaintiffs would be limited to funds actually owed or expended for treatment *actually* received. The court explicitly rejected the proposition that damages would be awarded for treatment that Nancy *would have* obtained had she been covered by the applicable BC/BS policy from the outset. The court also rejected the suggestion that Nancy would be reimbursed for treatment that she allegedly had to forego due to the fact that she was not covered by the BC/BS policy. The majority of the evidence submitted by Plaintiffs at trial and their arguments contained in their pretrial memorandum and proposed findings of fact address the two issues the court had already held were not areas of relevant inquiry. (*See* Pls.' Proposed Findings of Fact ¶¶ 43, 49; Report of Jane Mattson at 10-12; November 29, 1995 letter from Jane Mattson to David Wisneski at 4.) Moreover, Plaintiffs did almost nothing at trial to link the services provided with the applicable provisions in the BC/BS policy which would have provided coverage for these services. This was the essence of Plaintiffs' burden of proving their damages. Unfortunately, it appears from the court's reading of the terms of the applicable BC/BS policy that even if Plaintiffs had done more at trial in this regard, very little coverage would have been available under the policy for the services that Nancy Smith received. This is a sad result for the Plaintiffs in this case.

IV. Conclusions of Law

A. *Preliminary Findings*

(1) Plaintiffs' objection to Defendant's assertion of its affirmative defenses (1) that Nancy Smith has not required skilled nursing care since August 1, 1986, (2) that the care provided to Nancy Smith was not medically necessary and/or appropriate for the treatment of her condition, and (3) that when Nancy Smith became eligible for Medicare as a disabled beneficiary under Social Security after the initial twenty-four months of her disability, any medical services rendered thereafter would have been excluded from coverage under the applicable BC/BS plan is overruled.

(2) Defendant's objection to Plaintiffs' expert's testimony regarding her testimony as to which services provided to Nancy were "medically necessary" is sustained.

(3) Defendant's objection to Plaintiffs' expert's testimony as to pages 4-5 of her rebuttal report is sustained.

(4) All remaining objections by Defendant to Plaintiffs' expert's testimony are overruled.

B. *Reimbursable Charges from December of 1986 through April of 1988*

1. Seidle Charges

(5) Seidle's room and board charges from December of 1986 until April of 1988 were $30,675.

(6) Nancy Smith was certified as needing skilled nursing care for this period of time and the BC/BS medical policy to

which Nancy Smith could have converted would have covered these charges.

(7) The charges for physical therapy received by Nancy were $17,612.25.

(8) Nancy Smith's medical records from Seidle show that she was at a maintenance stage for physical therapy as of September 3, 1986.

(9) The charges for physical therapy for this period of time would not have been covered services under the BC/BS to which Nancy could have converted.

(10) In addition, Plaintiffs would not be entitled to reimbursement for the physical therapy provided by Joseph Smith after May 15, 1989, pursuant to the BC/BS policy to which Nancy could have converted.

(11) The pharmacy charges for Nancy from December 1986 until April 1988 total $319.27.

(12) The medical and surgical service charges total $960.40.

(13) The medical and surgical service charges for this period would have been covered under the BC/BS plan to which Nancy could have converted.

(14) The laboratory charges for December 1986 until April 1988 total $157.00.

(15) The laboratory charges would have been covered services under the BC/BS plan to which Nancy could have converted.

(16) The total charges for X-rays for Nancy from December 1986 until April 1988 were $355.50.

(17) These charges would have been covered under the BC/BS plan to which Nancy could have converted.

(18) The charges for speech therapy for the period of December 1986 through April 1988 were $1,539.50.

(19) The BC/BS policy to which Nancy could have converted would have covered these charges.

(20) Charges for personal care items for the period of time between December 1986 and April 1988 would not have been covered under the BC/BS policy to which Nancy could have converted.

(21) The total charges at Seidle that would have been covered by the BC/BC [sic] policy to which Nancy Smith could have converted for the period time [sic] from December 1986 through April 1988 are $34,006.67.[3]

(22) Seidle received $44,265.37 in payment from Hartford/Provident Insurance for the above services, pursuant to the VEBA Plan.

(23) Nancy Smith is not entitled to receive reimbursement for any of the Seidle charges that would have been covered from December 1986 until April 1988.

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2. Charges for Other Professional Services

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(24) The total charges for other professional services and supplies received by Nancy Smith from December 1986 through April 1988 is $2,243.43. (Def.'s Ex. 4, Attachment C.)

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[3] The supplemental information submitted by Plaintiffs was of limited assistance to the court in its review of the charges for services received for Nancy Smith for this period of time. Nancy's medical records and Plaintiffs' supplement show charges each month for "follow treatment." The medical records contain reference numbers for each "follow treatment" charge. Plaintiffs, however, failed to demonstrate what type of services these charges reflect and thus have failed to meet their burden of proving that these charges were for services covered under the applicable BC/BS plan.

(25) Charges for over-the-counter items are not reimbursable under the BC/BS policy to which Nancy Smith could have converted.

(26) Under the BC/BS policy to which Nancy could have converted, Plaintiffs would not have been entitled to more than the 80% reimbursement that they have already received for the rental of a wheelchair during this period of time.

(27) Under the applicable BC/BS policy, Plaintiffs would not have been entitled to more than the 80% reimbursement that they have already received for the services and/or items received from Teufel, Claremont Pharmacy, Norton.

(28) The charges for Nancy's eye exam would not have been covered under the BC/BS policy to which she could have converted.

(29) The charges for Nancy's oral surgery would not have been covered under the BC/BS policy to which she could have converted.

(30) Plaintiffs have not sustained their burden of demonstrating that the remaining charges for services for this period of time would have been covered under the BC/BS policy to which Nancy could have converted.

C. *Remaining Coverage Available to Nancy Smith*

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(31) Nancy Smith's coverage under the BC/BC [sic] policy to which she could have converted would have ceased once she became eligible for Medicare in June of 1988.

(32) Nancy could have converted to another BC/BS policy at the time that she became ineligible under the BC/BS to

which she could have converted at the time that she enrolled in the VEBA plan.[4]

(33) Nancy is no longer eligible for coverage under the BC/BS policy to which she could have converted at the time that she enrolled in the VEBA plan.

D. *Reimbursable Charges from May 1988 through March 24, 1994* [5]

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(34) The BC/BS policy to which Nancy Smith could have converted would not have covered her room charges at Seidle after April 8, 1988, because after that point she was no longer certified as needing skilled nursing care.

(35) All of the ancillary services provided by Seidle after April 8, 1988, would not have been reimbursable under the BC/BS policy to which Nancy Smith could have converted.

(36) Charges for Nancy Smith's personal care items for this period of time would not have been covered under the BC/BS plan to which she could have converted.

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[4] The only evidence Plaintiffs presented at trial regarding the policy to which Nancy could have converted at the time that her coverage under the applicable BC/BS policy ran out as a result of her eligibility for Medicare was the testimony of their expert Jane Mattson. Ms. Mattson did not identify the policy that Nancy Smith could have converted to at this time nor did she testify to the services that would have been covered under such a policy. The evidence presented was insufficient for the court to conclude that any services provided to Nancy Smith would have been covered under such a BC/BS policy after she became eligible for Medicare.

[5] Although the court has concluded that once Nancy Smith became eligible for Medicare she would no longer have been eligible under the applicable BC/BS policy, an alternative basis for its holding is that none of the services provided during this period of time would have been covered under the applicable BC/BS policy. The court has relied to a great extent on Attachment D of Defendant's expert report in concluding which services were covered services for this period of time. (Def.'s Ex. 4 at 23.)

(37) Charges for dental work received by Nancy Smith for this period of time would not have been covered by the BC/BS policy to which she could have converted.

(38) Charges for physical therapy after April 1988 would not have been covered under the BC/BS policy to which Nancy Smith could have converted for the same reasons that these services were not covered from December 1986 through April 1988.

(39) Charges for vision care are not charges that would have been covered under the BC/BS policy to which Nancy Smith could have converted.

(40) Charges for over-the-counter prescription drugs for this period of time would not have been covered under the BC/BS policy to which Nancy could have converted.

(41) Charges for "professional services" would not have been covered under the BC/BS policy to which Nancy could have converted because these services would have, or could have, been paid by Medicare.

(42) Charges for a hospital bed would not have been covered under the BC/BS policy because the equipment was not prescribed by a doctor and therefore not provided by a professional provider as mandated by the BC/BS policy.

(43) Charges for a motorized wheelchair would not have been covered under the BC/BS policy to which Nancy could have converted because the equipment was not prescribed by a doctor and therefore not provided by a professional provider as mandated by the BC/BS policy.[6]

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6. The issue of reimbursement for the wheelchair and hospital bed exemplify the difficulty the court was faced with in attempting to ascertain what services provided to Nancy Smith would have been covered under the BC/BS policy to which she could have converted. Plaintiffs maintain that had Nancy Smith been required to obtain a doctor's prescription for these items, she could have and would have secured one. (*See* Pls.' Ex. 36 at 4-5.) Plaintiffs' expert testified in this regard at trial. However, the court has found that Plaintiffs' expert was not qualified to testify to whether or not a doctor would have prescribed these items for Ms. Smith.

(44) Charges for a vocational rehabilitation consult would not have been covered under the BC/BS policy to which Nancy Smith could have converted.

(45) Charges for a homemaker and home modifications would not have been covered because the services and modifications were not prescribed by a doctor and therefore not provided by a professional provider as mandated by the BC/BS policy.

(46) Charges for attorney's fees would not have been covered under the BC/BS policy to which Nancy Smith could have converted.

An appropriate order will be issued by the court.

/s/SYLVIA H. RAMBO, Chief Judge
Middle District of Pennsylvania

Dated: April 26, 1996.

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

CIVIL ACTION NO. 1:CV-90-1541

NANCY M. SMITH and JOSEPH L. SMITH,
Her Husband, Plaintiffs

v.

PENNSYLVANIA HEALTH CORP., d/b/a THE REHAB HOSPITAL OF MECHANICSBURG, Defendant

ORDER

In accordance with the accompanying memorandum of law, IT IS HEREBY ORDERED THAT:

(1) Under the terms of the BC/BS policy to which Nancy Smith could have converted at the time that she elected to enroll in the VEBA plan, Plaintiffs are not entitled to any reimbursement for services provided to Nancy Smith from September 1986 through March 1994;

(2) The clerk of court is directed to enter judgment in favor of Defendant Pennsylvania Health Corporation, d/b/a The Rehab Hospital of Mechanicsburg, and against Plaintiffs and close the file.

/s/SYLVIA H. RAMBO, Chief Judge
Middle District of Pennsylvania

Dated: April 26, 1996.

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

CIVIL ACTION NO. 1:CV-90-1541 (Rambo, C.J.)

NANCY M. SMITH and JOSEPH L. SMITH,
Her Husband, Plaintiffs

v.

PENNSYLVANIA HEALTH CORP., d/b/a THE REHAB
HOSPITAL OF MECHANICSBURG, Defendant

ORDER

On September 8, 1995, the court conducted a conference in chambers with counsel. The court and counsel discussed the factual issues still to be resolved after the September 5, 1995, decision on the remedy available to Plaintiffs under ERISA §502(a)(3).

At the conference, Plaintiffs' counsel inquired about prejudgment interest. On page 17 of the September 5th memorandum, the court stated that it would not award prejudgment interest. At the September 8, 1995, conference, Plaintiffs' counsel proposed that an award of prejudgment interest is appropriate because the underlying dispute is a matter of contract. On the contrary, this is not an ordinary contract action. Indeed, the September 5, 1995, memorandum focused on the limitations that §502(a)(3) of ERISA places on any remedy awarded under that provision in light of the fact that it provides only for equitable relief. The court fashioned the remedy with equitable principles in mind, and held that prejudgment interest was not to be a component of the remedy.

At the September 8, 1995, conference, counsel also discussed the treatment Nancy Smith would have obtained had she been covered by a Blue Cross/Blue Shield ("BC/BS")

individual subscriber policy, and whether she is entitled to reimbursement for treatment that she had to forego in the absence of such coverage. The parties apparently misunderstand the court's ruling on appropriate reimbursement. Reimbursement will be made for funds actually expended or owed for treatment actually received by Nancy Smith, *if* such treatment was covered by the individual BC/BS policy that she could have converted to when she elected to join the VEBA Plan. To rule on such reimbursement, the court must be apprised of: (1) the extent of coverage Nancy would have received under the BC/BS policy she could have converted to when she elected to join the VEBA Plan; (2) the treatment actually received by Nancy that would have been covered by such individual policy, and the amounts expended or owed for such treatment and services; (3) the party or parties to whom reimbursement must be made for such covered treatment; and (4) the extent of coverage that remains available to Nancy after reimbursement, given any coverage limitations in the policy. Assuming there is unused coverage of any type, Nancy will not be reimbursed for services or treatment she could have received but did not, but all remaining coverage will be made available to her.

In accordance with the agreements reached on the other matters discussed in the September 8, 1995 conference, IT IS HEREBY ORDERED THAT:

(1) On or before October 6, 1995, Plaintiffs shall complete their investigation into the availability of alternative Blue Cross/Blue Shield individual subscriber policies to which Nancy Smith could have converted at the time she elected to join Defendant's VEBA Plan;

(2) On or before October 31, 1995, Defendant shall produce to Plaintiffs and the court an updated report from their expert witness;

(3) The parties shall make a good-faith attempt to stipulate to the Blue Cross/Blue Shield policy and coverage that would have been available, the reimbursement due, and the amount and extent of coverage remaining for Nancy Smith after reimbursement;

(4) On or before November 15, 1995, the parties shall file a joint status report on the results of their efforts to stipulate to the matters set forth in paragraph (3), above; and

(5) Upon review of the November 15, 1995, status report, the court will determine whether there are factual issues remaining for trial, and shall contact the parties accordingly.

/s/SYLVIA H. RAMBO, Chief Judge
Middle District of Pennsylvania

Dated: September 20, 1995.

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

CIVIL ACTION NO. 1:CV-90-1541 (Rambo, C.J.)

NANCY M. SMITH and JOSEPH L. SMITH,
Her Husband, Plaintiffs

v.

PENNSYLVANIA HEALTH CORP., d/b/a THE REHAB HOSPITAL OF MECHANICSBURG, Defendant

MEMORANDUM

I. Introduction

In this action under the Employment Retirement Security Income [sic] Act (ERISA), 29 U.S.C. §§1001 *et seq.*, the court will now resolve two related matters: (1) the nature and scope of any remedy available to Plaintiff; and (2) Defendant's motion for reconsideration of this court's February 16, 1995, memorandum and order holding Defendant liable to Plaintiff. The February 16th liability memorandum[1] contained an exhaustive account of the background of this action. Therefore, only the most recent developments will be set forth herein.

II. Recent Background

In the liability memorandum, the court found Defendant liable to Plaintiffs under ERISA on theories of breach of

[1] On February 16, this court also issued a memorandum and order denying Defendant's motion for summary judgment on the question of damages. The court will distinguish the two memoranda as the "liability memorandum" and the "damages memorandum."

fiduciary duty and equitable estoppel. The court found that Defendant had acted as a fiduciary within the meaning of ERISA, that it had misrepresented the long-term nursing care benefits available to Nancy Smith under its new self-insured employee health benefits plan (the "VEBA Plan"), and that Plaintiffs had detrimentally relied upon Defendant's misrepresentations when Joseph Smith elected to enroll Nancy Smith in the VEBA Plan, rather than exercise her right to convert from the Blue Cross/Blue Shield ("BC/BS") group plan to an individual BC/BS policy. The questions remaining for decision concern the remedy ERISA provides for situations such as this one. In that regard, in the damages memorandum of February 16th, the court rejected Defendant's contention that the holding in *Mertens v. Hewitt*, 509 U.S. ___, 113 S. Ct. 2063 (1993), outright precludes the award of the relief sought by Plaintiffs. The court also expressed skepticism as to Defendant's alternative position, which was that any remedy had to be limited by Plaintiff's failure to obtain replacement insurance coverage. The court further noted that even if that position were viable, there would be issues of fact that would preclude summary judgment at that time.[2]

The court then held an in-chambers conference on February 24, 1995, to develop an approach to resolving the remaining legal and factual disputes about the remedy. There, the court indicated that it would allow the parties ninety days to complete any discovery and brief any issues relevant to the question of the remedy. Immediately following that conference, the court *sua sponte* reconsidered this approach, and contacted the parties by telephone to ascertain their willingness to pursue settlement discussions before Magistrate Judge J. Andrew Smyser. The parties agreed to do so, and by order

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[2] That issue has been characterized, or mischaracterized, as it were, as a "mitigation of damages" dispute, *see infra*.

dated February 27, 1995, the court referred the case to Magistrate Judge Smyser for settlement sessions. Three sessions were held over the next several months, but the efforts proved unsuccessful.

After the settlement efforts ended, the court again discussed with the parties an approach to resolving the dispute about the remedy. The court concluded that additional briefing on the question of the remedy would be unproductive, inasmuch as each party conceded that it had no case law to support its positions. Instead, on May 19, 1995, the court permitted oral argument, which included argument on the "mitigation of damages" issue.

Meanwhile, the motion for reconsideration arose out of the following events. At the February 24th in-chambers conference, the parties had pointed out several inaccuracies in the factual findings in the liability memorandum, which mostly were due to the court's unawareness of changes in Nancy Smith's circumstances since the commencement of this action. Defendant was concerned that the court would rely upon these inaccurate findings when deciding the remedy question. The parties suggested at the conference that they be given time to attempt to stipulate to correct the findings. The court agreed, and further allowed that if they could not reach such a stipulation, Defendant could utilize a Rule 59 motion for reconsideration to bring the matter to the court for resolution. To preserve the timeliness of any such motion, the court agreed to an enlargement of time whereby Defendant would have ten days from the date the parties notified the court that they were unable to reach a stipulation. This understanding was confirmed by order dated March 8, 1995.

On May 19, 1995, Defendant submitted a letter stating that the parties had been unable to reach a stipulation. The letter was accompanied by Defendant's motion for reconsid-

eration, as anticipated. The parties completed the briefing of that motion on July 6, 1995.

III. Discussion

A. *The Remedy*

The dispute between the parties over the remedy brings into play the distinction between the rights and remedies that ERISA provides to individual beneficiaries of employee benefit plans, and the rights and remedies provided only to benefit plans. Defendant has asserted repeatedly that the relief sought by Plaintiffs in this case constitutes an award of damages that ERISA does not provide for individual plan beneficiaries.

In *Curcio v. John Hancock Mut. Life Ins. Co.*, 33 F.3d 226 (3d Cir. 1994), and *Bixler v. Central Pa. Teamsters Health & Welfare Fund*, 12 F.3d 1292 (3d Cir. 1993), the Third Circuit Court of Appeals established that: (1) Section 502(a)(3) of ERISA[3] provides a cause of action not only to employee welfare benefit plans, but also to individual plan beneficiaries; and (2) that individual beneficiaries may utilize 502(a)(3) to obtain equitable relief under a theory of breach of fiduciary duty. The Third Circuit did not establish, however, just what such equitable relief might encompass, and that is the question that has occupied the parties. Defendant's position has been in essence that if relief involves the payment of money to the individual, it constitutes "damages" that may not be awarded under §502(a)(3). Plaintiffs disagree, but further suggest that to the extent the relief requested constitutes damages, § 502 (a) (2) allows them to obtain such damages, an unsupported

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[3] 29 U.S.C. § 1132 (a) (3).

position that will be addressed briefly, *infra*. The court is concerned here with §502(a)(3).

In a previous memorandum, this court observed that, contrary to Defendant's position, *Curcio* and *Bixler* do not suggest that if relief involves the payment of money in some fashion, it may not be awarded under §502(a)(3). *See Smith v. Pennsylvania Health Corp.*, No. 1:CV-90-1541, at 2 (February 16, 1995) (Memorandum and Order). On June 28, 1995, the Third Circuit issued *In re Unisys Corp. Retiree Medical Benefit "ERISA" Litig.*, 57 F.3d 1255 (3d Cir. 1995) (*"In re Unisys I,"*).[4] *In re Unisys I* confirms this court's reading of *Curcio* and *Bixler* as not precluding awards under §502(a)(3) simply because they involve the payment of money. *In re Unisys I* involved retirees who brought an ERISA action against their former employer after it changed from a post-retirement medical benefits plan that provided medical benefits for life at the employer's cost, to a plan that required the retirees to pay their own premiums. Although the plan contained a reservation of rights clause that allowed the employer to eliminate or change the plan at any time, the employer allegedly informed the retirees repeatedly that their benefits would be continued for life, and the summary plan description assured them of that as well. The employer moved for summary judgment in its favor on the grounds of the reservation of rights clause. *See In re Unisys I*, 57 F.3d at 1257-1260.

The district court granted summary judgment in favor of the employer, but certified for immediate interlocutory appeal the following questions: (1) whether the facts before it could support a breach of fiduciary claim under ERISA; and (2) if so, whether equitable relief was available to individual plan participants. *See In re Unisys I*, 57 F.3d at 1261 & n. 9. The Third Circuit accepted the interlocutory appeal, and held that

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[4] This is one of two decisions issued the same day under the same caption.

the retirees could maintain a breach of fiduciary duty claim based on the facts before the district court and, assuming they prevailed on the claim, they could obtain equitable relief under §502(a)(3). The court "reaffirm[ed] [the] conclusion in *Bixler* that equitable relief running to an individual falls within the scope of section 1132(a)(3)'s language and of ERISA's broad remedial purpose." *In re Unisys I*, 57 F.3d at 1269. In discussing the scope of such equitable relief, the Third Circuit wrote:

> A question left unanswered by *Bixler* is the form of equitable relief available. . . . Both the district court and the . . . retirees agree that the retirees are not entitled to money damages for a breach of fiduciary duty. Instead, the retirees seek an injunction ordering specific performance of the assurances Unisys made, restitutionary reimbursement for back benefits, and restoration of the status quo ante for the . . . early retirees by rescinding their retirement agreements. These are remedies which are restitutionary in nature and thus equitable. . . . It will be for the district court to determine which of these remedies are appropriate under the circumstances of these individual claims.[5]

In re Unisys I, 57 F.3d at 1268-68 [sic].

Thus, the Third Circuit has established that §502(a)(3) allows the award of equitable relief to individuals for the type of fiduciary liability assessed against Defendant in this case.

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[5] In setting forth this conclusion, the Third Circuit quoted from its decision in *Curcio*, 33 F.3d at 238-39 ("[W]e hold that Mrs. Curcio's alternate argument [that Capital Health breached its fiduciary duty] provides additional support for our conclusion that Capital Health is liable to Mrs. Curcio for the $150,000.00 in supplemental AD & D' representing full enforcement of the promise that had been made), as well as from *Howe v. Varity Corp.*, 36 F.3d 746, 756 (8th Cir. 1994), *cert. granted*, 115 S.Ct. 1992 (April 24, 1995) (award of monies plaintiffs would have received if they had remained members of the M-F plan could not properly be characterized as damages; rather the payments were restitution). *See In re Unisys*, 57 F.3d at 1269.

Further, while the Third Circuit confirmed that traditional compensatory and punitive damages are not within the category of equitable relief available under §502(a)(3), it also confirmed that the payment of benefits that an individual beneficiary should have received, but did not as a result of a defendant's wrongful conduct, is not compensatory relief that would be unavailable under §502(a)(3). Rather, such payments are restitutionary in nature and, therefore, constitute equitable relief properly awardable under §502(a)(3). In short, the fact that a particular form of relief involves the exchange of money does mean that such relief is unavailable under §502(a)(3).

The issue now to be resolved in this case is the extent to which the relief requested by Plaintiffs is within the scope of equitable relief permitted under §502(a)(3). Plaintiffs have requested the following forms of relief, all of which they characterize as equitable within the meaning of §502(a)(3): (1) reimbursement for money payments made for Nancy Smith's skilled nursing care and other medical and rehabilitative care; (2) reimbursement for physical therapy and rehabilitative services provided by Joseph Smith; (3) future medical and rehabilitative expenses until such expenses reach the limit of the $1,000,000,000 skilled nursing care benefit provided through Defendant's former BC/BS group major medical policy; (4) future medical coverage in accordance with the BC/BS group policy; (5) an order enjoining Defendant from denying Nancy Smith coverage under the BC/BS plan; (6) an order directing Defendant to disgorge excess profits or savings unjustly enjoyed as a result of denying benefits to Nancy Smith; (7) prejudgment interest; (8) legal expenses and attorneys' fees; and (9) other equitable and remedial relief as the court deems proper. In addition, relying upon §502(a)(2), Plaintiffs request damages for emotional distress and physical and mental pain and suffering (hereinafter "compensatory damages"). *(See*

Plaintiffs' September 23, 1994, pretrial memorandum, at 7-9; Plaintiffs' brief in opposition to Defendant's second motion for summary judgment, at 6-10.)

The court will not entertain Plaintiffs' request for compensatory damages. There is nothing in §502(a)(2) or the case law to suggest that it can be utilized to obtain compensatory damages for an individual beneficiary in these circumstances. Furthermore, as Plaintiffs apparently concede, it is beyond argument that §502(a)(3) does not provide for such damages.

Given the Third Circuit's pronouncements in this area of the law, this court has no trouble finding that appropriate equitable relief in this case would include reimbursement for money payments already made for Nancy Smith's skilled nursing care, and for coverage for future skilled nursing care, medical and rehabilitative care up to the amount to which she would have been entitled absent Defendant's misrepresentations. That statement, however, merely begs the question: What *is* the limit of the benefit that Nancy Smith would have had access to absent Defendant's misrepresentations? Plaintiffs argue that she is entitled to past and future payments and coverage up to the $1 million skilled nursing care benefit provided through Defendant's former BC/BS major medical group policy. Defendant, of course, disagrees.

At oral argument, the parties discussed three possible theories of reimbursement: The first is Plaintiffs' "vested rights" position, which, as noted, asserts that Nancy Smith is entitled to the unused portion of the entire $1 million benefit provided under Defendant's former BC/BS group plan. The second theory is that Nancy Smith is entitled to the unused portion of the $250,000.00 skilled nursing care benefit that Defendant claims was available under the individual BC/BS policy available to Nancy Smith at the time of her conversion. That is Defendant's alternative theory. The third theory com-

prises Defendant's preferred theory: that Nancy Smith is entitled to be reimbursed for $31,664.96, which Defendant states is the amount of medical expenses incurred by Nancy Smith during the one year following the date that Defendant's new group plan ceased making payments for her skilled nursing care benefit. The theory here is that, having lost the ability to convert, Nancy Smith nevertheless should have purchased the BC/BS individual policy, which would have included a one-year preexisting condition exclusion, but which would have provided the $250,000.00 skilled nursing care benefit after that one year exclusionary period expired.

For Plaintiffs' "vested rights" theory to prevail, the court must find that Nancy Smith had an accrued right to the $1 million benefit. To make that finding, the court would have to find in turn that, as to Nancy Smith, Defendant could not alter its employee benefits plan so as to reduce the scope of the skilled nursing care benefit once Nancy Smith suffered the stroke (triggering her coverage under the $1 million benefit). The question, it seems, is whether an employer is precluded from altering a welfare benefits plan once the employee has utilized it to obtain particular coverage. In other words, does a particular benefit within an ERISA-governed plan "vest" for an employee once he or she activates a claim for coverage under it?

Plaintiffs have provided no support for this notion, and the court suspects none exists. The problem for Plaintiffs is that ERISA does not require employers to provide welfare benefit plans, or require that if a welfare plan is provided, the benefits must vest at a particular level. An employer is free, unless it establishes a plan that states otherwise, to reduce or otherwise alter the welfare benefits provided to its employees. *See In re Unisys Corp. Retiree Med. Benefit "ERISA Litig."*, 58 F.3d 896, 901 (3d Cir. 1995);[6] *Smith v. Hartford Insur.*

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[6]. This is the second of two decisions issued in the *In Re Unisys* ERISA litigation on the same day. Hereinafter, the court will refer to it as *In re Unisys-II*.

Group, 6 F.3d 131, 136 (3d Cir. 1993); *McGann v. H & H Music Co.*, 946 F.2d 401, 405 (5th Cir. 1991); *Moore v. Metropolitan Life Insur. Co. I*, 856 F.2d 488, 492 (2d Cir. 1988). This follows the well-recognized distinction between pension plans, which are subject to specific and stringent vesting requirements under ERISA, and welfare benefit plans, which are subject to no automatic vesting requirements. *See In re Unisys II*, 58 F.3d at 901. As noted, vested medical benefits may be provided under the specific terms of a welfare plan if the employer so agrees, but should there be a dispute about vesting, the employee bears the burden of proving by a preponderance of the evidence that the employer intended vesting. *Id.* (citing to *Howe v. Varity Corp.*, 896 F.2d 1107 (8th Cir. 1990)).

In this case, Plaintiffs have pointed to nothing in Defendant's former BC/BS group plan to suggest that vested medical benefits were promised or otherwise intended by Defendant. Instead, at oral argument, Plaintiffs implied that when Defendant exercised the right to change its welfare benefits plan in the midst of Nancy Smith's skilled nursing care treatment, she could have and would have obtained individual coverage by BC/BS under a conversion provision in the former BC/BS group plan, which would somehow have preserved her $1 million dollar skilled nursing care benefit. The court does not understand how Plaintiffs believe that would have come about.

Of course, the court has held already that Nancy Smith could have and would have converted to the BC/BS policy. But for Plaintiffs to prevail on their theory, they would have to demonstrate as a matter of law that, regardless of the terms of the individual policy available to Nancy Smith upon conversion, some principle of insurance conversion coverage, or ERISA itself, would have required BC/BS to append the $1 million skilled nursing care benefit to such policy because she had already begun to take advantage of that benefit under the

BC/BS group plan. The court found no support such a notion, and Plaintiffs have pointed to none themselves. Accordingly, Plaintiffs' "vested rights" theory will be rejected.

The court is not persuaded by the third theory, which Defendant offers as its preferred position. This theory depends upon the notion that Nancy Smith, having been deprived of the $1 million benefit available under the group plan as a result of her employer's change in plans, and having been deprived of the opportunity to convert to an individual policy, should have located and purchased BC/BS or other policy in order to mitigate her loss of insurance coverage while Plaintiffs pursued this legal action. This issue has been characterized at times in this litigation as a "failure to mitigate" theory, although Defendant now would retreat from that characterization. (*See* Defendant's Letter of May 23, 1995, addressed to the court.) In any case, Plaintiffs' goal in characterizing it as the failure to mitigate is to prevail on their corollary argument—that the issue should have been raised as an affirmative defense.

The court does not view this question as a typical mitigation of damages defense and does not believe Defendant must have raised it as an affirmative defense in order to have it considered by the court. Having said that, the court rejects the idea that Plaintiffs' recovery is limited by their failure to go out and purchase other insurance while they challenged the denial of her insurance coverage. Simply put, the proposition does not comport with this court's senses of equity and common sense. Defendant has pointed to no support for this notion and the court found none through its independent research. Accordingly, this "mitigation of damages" theory will be rejected.

The second theory—that Nancy Smith is entitled to be reimbursed in the amount of whatever skilled nursing care benefit would have been available to her under the individual

BC/BS policy to which she could have converted—is the only one the court finds viable as a matter of law. It flows from the facts of the case—Nancy Smith could not have remained on the BC/BS group plan once Defendant resolved to eliminate it, but she could and would have switched to a BC/BS individual policy group had she known that under the VEBA plan, she would be viewed as having exhausted her skilled nursing care coverage. Despite an absence of factually similar case law, this resolution remains the only benefits reimbursement theory that is consistent with ERISA's absence of automatically vested medical benefits, general concepts of equitable relief, and common sense.

Having so resolved the benefits reimbursement question, the court still is faced with a factual question: What benefits were available to Nancy Smith at the time? Here, the parties may again disagree. Defendant, as noted, claims to have unassailable proof that the BC/BS individual policy available at that time contained a $250,000 skilled nursing care benefit. Plaintiffs have not indicated their acceptance of that claim. It may be that Plaintiffs can prove in fact that Nancy Smith could have converted to an existing individual BC/BS policy which, like the Defendant's former group policy, also contained the $1 million benefit, or to a policy with a provision that in some way permitted her to continue receiving that greater benefit even though she had converted, or to a policy that otherwise provided her with a skilled nursing care benefit greater than the $250,000.00 benefit to which Defendant refers. This is a question of fact the resolution of which is dependent upon determining which individual BC/BS policy or policies would have been available to Nancy Smith at the time.

The court urges Plaintiffs to refrain from further prolonging this already protracted litigation by conceding, if appropriate, to Defendant's position on this factual issue. The court intends to bring this matter to a close as soon as possible. The

court also urges Plaintiffs to recognize that should the dispute be resolved in favor of a higher benefit than Defendant claims existed, it will not stand as an endorsement of their "vested rights" resolution.

Still to resolve is the extent to which the other items of relief requested by Plaintiffs fall within the relief permitted under § 502 (a) (3). Plaintiffs requested reimbursement for Joseph Smith's physical therapy and rehabilitative services to Nancy Smith. The court finds that such relief is akin to traditional compensatory damages. Mr. Smith is not a health care provider and, as such, the court does not perceive how an insurer could have paid him for services, had proper coverage been in place. Moreover, this request for reimbursement is based upon the assertion that Joseph Smith had to forego earning opportunities in order to provide Nancy Smith with the physical therapy services—i.e., he would not have lost earnings had insurance coverage been available to pay a physical or rehabilitative therapist for the services he, instead, provided to his wife. In short, this is a request to recover Joseph Smith's lost wages, rather than to obtain reimbursement for personal funds expended in the absence of coverage. The court does not believe such relief is available under § 502(a)(3).

Nor can the court grant Plaintiffs' requests for an order ensuring future medical coverage in accordance with the BC/BS group policy plan, and enjoining Defendant from denying Nancy Smith coverage under that plan. The group plan is no longer in place, inasmuch as Defendant discontinued it as was permissible under ERISA and the terms of the plan. The court can direct only that Nancy Smith be reimbursed in accordance with any policy she could have obtained by conversion.

The court also must deny Plaintiffs' request for an order directing Defendant to disgorge excess profits or savings un-

justly enjoyed as a result of denying benefits to Nancy Smith, and for prejudgment interest. The court's goal when devising a remedy under § 502(a)(3) is to arrive at an equitable result. Thus, the court cannot ignore Defendant in the matter. As the court observed in the February 16th liability memorandum, Defendant supported Nancy Smith's attempt to obtain skilled nursing care benefits from the VEBA plan. Defendant and the VEBA plan acknowledged the unfortunate confusion and consequences of Defendant's misrepresentations, and attempted to make amends by providing her with coverage under the VEBA plan for a time. *See Smith v. Pennsylvania Health Corp.*, No. 1:CV-90-1541, at 22 (February 16, 1995) (Memorandum and Order).

Finally, the court must evaluate Plaintiffs' request for legal expenses and attorneys' fees, which is governed by §502(g) of ERISA, and the factors set forth by the Third Circuit to guide district courts in the exercise of their discretion in the area. Those factors include:

(1) the offending parties' culpability or bad faith;

(2) the ability of the offending parties to satisfy an award of attorneys' fees;

(3) the deterrent effect of an award of attorneys' fees against the offending parties;

(4) the benefit conferred on members of the pension plan as a whole; and

(5) the relative merits of the parties' positions. *Ursic v. Bethlehem Mines*, 719 F.2d 670, 673 (3d Cir. 1983).

The Third Circuit has directed that district courts presented with a request for attorneys' fees under § 502(g) are to articulate their reasoning and conclusions as to each of the five *Ursic* factors. *Anthuis v. Colt Indus. Operating Corp.*, 971 F.2d 999, 1012 (3d Cir. 1992). The Circuit has also indicated that

there is no presumption in favor of awarding attorneys' fees to a successful ERISA plaintiff. *See Ellison v. Shenango, Inc. Pension Bd.*, 956 F.2d 1268, 1273 (3d Cir. 1992). The existence of bad faith, however, is clearly not a prerequisite to an award under § 502(g). *See generally McPherson v. Employees' Pension Plan*, 33 F.3d 252 (3d Cir. 1994). With these principles in mind, the court will analyze the five *Ursic* factors.

The first factor, the offending parties' culpability, was the subject of analysis in the *McPherson* decision. The *McPherson* court established that culpability is not consonant with bad faith, or "sinister motive," but is rather, a question of fault or the breach of a legal duty. *McPherson*, 33 F.3d at 256-57. Thus, culpability may be found if there were repeated misrepresentations and/or adherence to an untenable position, resulting in the wrongful deprivation of benefits to an ERISA beneficiary. *See id.* at 257-58. Here, Defendant's misrepresentations, though not made with bad motive, were the sole reason for Nancy Smith's lack of insurance coverage. Although Defendant sympathized with her position, its unwillingness to accept responsibility for it over the past several years simply perpetuated the wrong. Therefore, the court finds that the culpability factor weighs in favor of an award of attorneys' fees.

The second factor, the ability of the offending party to satisfy an award of attorneys' fees, weighs in favor of making an award. There is nothing to suggest that Defendant, a corporate subsidiary of a larger health care corporation, cannot satisfy a reasonable award of attorneys' fees.

The third factor, the deterrent effect an award might have against the offending party, also weighs in favor of an award of attorneys' fees. The *McPherson* court emphasized that bad faith is not integral to the question of deterrence any more than to the question of culpability. *See McPherson*, 33 F.3d at 258. The question is simply whether the offending party and

other similarly situated parties are more likely to take precautions to prevent a repeat of the conduct that gave rise to the prevailing party's injury. *See id.* Here, the court finds that it will serve the objectives of ERISA to put Defendant and other employers on notice to exercise great care when providing information to employees about the features of ERISA-governed employee benefit plans. Accordingly, the court finds that the third *Ursic* factor weighs in favor of an award of attorneys' fees.

The fourth factor, the benefit conferred on members of the pension plan as a whole, has no particular significance to this case. Nonetheless, the court does not find that it weighs against an award of attorneys' fees. It is a neutral factor under the circumstances of this case.

Finally, the fifth factor, the relative merits of the parties' positions, weighs in favor of awarding attorneys' fees. In *McPherson,* the Third Circuit clarified that for this factor to weigh in favor of an award, it is not necessary to find that the defendant's position was so meritless as to evidence bad faith. *Id.* at 258. By the same token, however, the fact that defendant failed to prevail in its positions does not alone mean that a plaintiff is entitled to an award. *Id.* This court interprets the Third Circuit's guidance to be that the merits of each party's position must be weighed in relation to each other and the repercussions of those positions. Here, the court notes that the case law with respect to Defendant's status and obligations as a fiduciary was in a muddled state at the outset of this litigation. On the other hand, given the state of the law, and the repercussions for Plaintiffs and others similarly situated to them, Plaintiffs' position in this litigation has always resounded with merit. Furthermore, as the Third Circuit's view of the relevant law became increasingly clear, Defendant's position became increasingly unmeritorious over the course of the litigation but there was no retreat from it. Considering then the *relative*

merits of the parties' positions, the court finds that this factor weighs in favor of an award of attorneys' fees.

Thus, the court finds that four of the five *Ursic* factors weigh in favor of an award of attorneys' fees in this case. The court further finds that each of the four favorable factors weighs firmly in favor of the award, while the other factor is neutral. In other words, it does not encourage a contrary decision. Accordingly, the court finds that an award of attorneys' fees and legal expenses is an appropriate form of equitable relief in this case.

Having addressed all of the categories of relief requested by Plaintiffs, the court will turn its attention to Defendant's motion for reconsideration.

B. *The Motion for Reconsideration*

Defendant filed a motion for reconsideration of certain factual findings contained in the February 16th liability memorandum. The motion is not actually directed to the court's liability ruling but, rather, is concerned with correcting certain background findings made by the court based on now outdated information about Nancy Smith's circumstances. Defendant is simply attempting to ensure that certain inaccurate findings will not be interpreted as precluding Defendant from arguing contrary to those findings in the context of the remedy. Defendant also expressed concern that the court might take the position that Defendant now objects only to certain factual inaccuracies, it will have waived its right to challenge the liability ruling. The court assures Defendant that it does not view Defendant as having waived any challenge to the liability ruling, and that it understands the purpose and scope of the motion for reconsideration.

Without belaboring the precise findings at this stage of the proceedings, the court understands that it made certain inaccurate findings. It is obvious that the court had outdated information when writing its memorandum and order, and that Defendant merely seeks to correct the findings to ensure that the court will be correct when making the ultimate findings on the available BC/BS policy, the amount of medical and other expenses incurred and/or paid by the VEBA plan thus far, and Nancy Smith's current rehabilitative status. The court declines to make new findings now, however, as the circumstances are likely to change yet again prior to the ultimate factual determination on the relief. The court will await the completion of the factfinding proceedings pertinent to the relief to be awarded ultimately. Accordingly, Defendant's motion for reconsideration will be granted, with factual corrections to be made at a later date.

IV. Conclusion

The remedy to be awarded Plaintiffs will include reimbursement for past skilled nursing care and other medical and rehabilitative expenses, and coverage for future skilled nursing care and other medical and rehabilitative expenses, up to the limit of the individual BC/BS policy that Nancy Smith could have converted to when she changed to Defendant's new VEBA plan. The final order awarding the remedy will be entered after the court and/or the parties resolve the factual disputes pertinent to the policy, the covered incurred expenses to date, the amounts paid by the VEBA plan already, and any other pertinent factual matters. The court also will award legal expenses and attorneys' fees, and will provide an opportunity for Plaintiffs to submit a petition for such expenses and fees after the ultimate factual finding on the remedy has been

made. Defendant's motion for reconsideration will be granted, but the court will await to correct the factual findings referenced in the motion until it makes the ultimate factual findings on the remedy. An appropriate order will be entered.

/s/SYLVIA H. RAMBO, Chief Judge
Middle District of Pennsylvania

Dated: September 5, 1995.

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

CIVIL ACTION NO. 1:CV-90-1541 (Rambo, C.J.)

NANCY M. SMITH and JOSEPH L. SMITH,
Her Husband, Plaintiffs

v.

PENNSYLVANIA HEALTH CORP., d/b/a THE REHAB HOSPITAL OF MECHANICSBURG, Defendant

ORDER

And now, in accordance with the accompanying memorandum, IT IS HEREBY ORDERED THAT:

(1) Plaintiffs are entitled to reimbursement for past skilled nursing care and other medical and rehabilitative expenses, and coverage for future skilled nursing care and other medical and rehabilitative expenses, up to the amount of the individual Blue Cross/Blue Shield policy that Nancy Smith could have converted to rather than enrolling in Defendant's new VEBA plan;

(2) The total amount of past and future reimbursement shall be reduced by all amounts paid by the VEBA plan for Nancy Smith's skilled nursing and other medical and rehabilitative care;

(3) Plaintiffs are entitled to an award of attorneys' fees and expenses;

(4) Defendant's motion for reconsideration is GRANTED, with the understanding that the court will make the final factual determinations referenced in Defendant's motion for reconsideration when it makes the factual findings necessary to awarding the ultimate relief in this matter; and

(5) The court will conduct a conference on Friday, September 8, 1995 at 8:30 a.m. in the chambers of Courtroom No. 3, Eighth Floor, Federal Building, Third and Walnut Streets, Harrisburg, Pennsylvania, to discuss the procedure to be utilized in making all factual determinations necessary to the relief to be awarded in accordance with this memorandum, and to discuss the timing for submission of a petition for attorneys' fees.

/s/SYLVIA H. RAMBO, Chief Judge
Middle District of Pennsylvania

Dated: September 5, 1995.

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

CIVIL ACTION NO. 1:CV-90-1541 (Rambo, C.J.)

NANCY M. SMITH and JOSEPH L. SMITH,
Her Husband, Plaintiffs

v.

PENNSYLVANIA HEALTH CORP., d/b/a THE REHAB HOSPITAL OF MECHANICSBURG, Defendants

MEMORANDUM AND ORDER

By memorandum and order issued this date, the court set forth its adjudication of the liability of Defendant to Plaintiffs under theories of equitable estoppel and breach of fiduciary duty. The court granted judgment in favor of Plaintiffs on both claims. Now before the court is Defendant's motion for summary judgment, which addresses the question of the recovery available to Plaintiffs, and which was stayed pending the disposition of the threshold liability issues. Also before the court are motions *in limine*, not yet ripe, filed by the Plaintiffs.

Defendant's motion is premised primarily on the contention that the Supreme Court established in *Mertens v. Hewitt Assoc.*, 508 U.S. , 113 S.Ct. 2063 (1993), that ERISA does not provide a remedy of damages for the causes of action asserted herein. The court disagrees with Defendant's view of the holding in *Mertens*. At issue there was the liability of a non-fiduciary actuary to make up all direct and consequential losses that accrued to an employee benefits plan due to his actuarial miscalculations. Notwithstanding the Court's references to the availability of damages under § 502(a)(3), its attention was devoted, in fact, to the question of the liability of non-fiduciaries for damages of any type under § 502 (a)(3).

Thus, Defendant's reading of *Mertens* is broader than is apparently justified.

Here, Plaintiffs seek only the specific benefit due them from an entity that has been held to be a fiduciary, which distinguishes this case factually and legally from *Mertens*, both in terms of the recovery sought and the identity of the defendant. Furthermore, in both *Curcio v. John Hancock Mut. Life Ins. Co.*, 33 F.3d 226 (3d Cir. 1994), and *Bixler v. Central Pa. Teamsters Health & Welfare Fund*, 12 F.3d 1292 (3d Cir. 1993), the Third Circuit clearly signalled its view that beneficiaries of ERISA plans may utilize § 502(a)(3) to recover specific benefits that became unavailable to them because of a fiduciary's misrepresentation. The notion that such a remedy involves the payment of money and, thus, should be termed a "compensatory damage" apparently would not change the Third Circuit's view of the availability of the remedy.

One other aspect of Defendant's summary judgment motion must be addressed. Defendant has asserted that even if the type of remedy requested by Plaintiffs is available to them, any award must be limited by Plaintiffs' failure to mitigate. Defendant has provided no meaningful support for this position in the context of ERISA. In any case, even if Defendant's failure to mitigate theory is supportable, there are disputed issues of fact that preclude summary judgment. Accordingly, the court will deny Defendant's motion for summary judgment in its entirety.

The motions *in limine* filed by Plaintiffs concern documentary and expert evidence identified and sought to be relied upon by Defendant. Because the evidence was pertinent to the remedy question, the court stayed the briefing of the *in limine* motions pending adjudication of liability and disposition of the summary judgment motion. Plaintiffs' motions are premised on the lateness of Defendant's identification of the

documents and experts. The court notes that defense counsel indicated to the court several weeks ago that it would not oppose an additional period of discovery, or any other strategy that might aid the disposition of this matter.

It may be that legal briefing of the mitigation issue is appropriate at this stage and, if the mitigation issue is viable, it may be necessary to allow for limited additional discovery. In short, a conference in which the parties can present to the court their views of the proper approach to the remainder of this case must be scheduled at this juncture. Meanwhile, in view of the posture of the case at this point, denial of Plaintiffs' motions *in limine*, with the right to reinstate, is the best approach.

Accordingly, IT IS HEREBY ORDERED THAT:

(1) Defendant's motion for summary judgment is DENIED;

(2) Plaintiffs' motions *in limine* are DENIED, without prejudice to reinstate them as may be appropriate at a later time;

(3) On or before February 22, 1995, the parties shall confer with each other concerning the approach to the next phase of these proceedings; and

(4) The court will conduct a conference with counsel to discuss the next phase of these proceedings on Friday, February 24, 1995 at 10:00 A.M. in the chambers of Courtroom No. 2.

/s/SYLVIA H. RAMBO, Chief Judge
Middle District of Pennsylvania

Dated: February 16, 1995.

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

CIVIL ACTION NO. 1:CV-90-1541 (Rambo, C.J.)

NANCY M. SMITH and JOSEPH L. SMITH,
Her Husband, Plaintiffs

v.

PENNSYLVANIA HEALTH CORP., d/b/a THE REHAB HOSPITAL OF MECHANICSBURG, Defendant

ORDER

In accordance with the accompanying memorandum, IT IS HEREBY ORDERED THAT:

1) Judgment is granted in favor of Plaintiffs on the liability aspects of their equitable estoppel and breach of fiduciary claims against Defendant Pennsylvania Health Corporation d/b/a the Rehab Hospital of Mechanicsburg.

2) The Clerk of Court is directed to defer the entry of judgment until the conclusion of this case.

3) A separate order will be issued in the future on the amount Plaintiffs may recover.

/s/SYLVIA H. RAMBO, Chief Judge
Middle District of Pennsylvania

Dated: February 16, 1995.

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

CIVIL ACTION NO. 1:CV-90-1541 (Rambo, C.J.)
NANCY M. SMITH and JOSEPH L. SMITH,
Her Husband, Plaintiffs
v.
PENNSYLVANIA HEALTH CORP., d/b/a THE REHAB
HOSPITAL OF MECHANICSBURG, Defendant
MEMORANDUM

I. Introduction

Before the court for decision is whether Defendant, the Pennsylvania Health Corporation, d/b/a The Rehab Hospital of Mechanicsburg ("Rehab") is liable to Plaintiff under the Employment Retirement Security Income [sic] Act (ERISA), 29 U.S.C. §§ 1001 *et seq.* (1988). The matter is before the court for the second time, having been remanded for consideration in light of the decision of the Third Circuit Court of Appeals in *Smith v. Hartford, et al.*, 6 F.3d 131 (3d Cir. 1993). As explained more fully below, the issue of Rehab's liability to Plaintiff has been bifurcated from the question of the recovery that can be obtained should the liability question be decided in Plaintiff's favor.

II. Procedural Background[1]

This regrettable litigation is now more than four and one-half years old. On July 17, 1990, Plaintiffs filed a suit in the Court of Common Pleas of Cumberland County against several insurers, Rehab, Rehab's employee health care plan,

[1] Exhaustive accounts of the early procedural history of this matter are contained in the Third Circuit's decision, *see supra*, and this court's memorandum and order of April 16, 1992, and will be summarized only briefly herein. Only recent procedural events pertinent at this juncture, will be explained in full detail herein.

and the plan's administrators and alleged fiduciaries. The suit arose from the alleged wrongful denial of skilled nursing care benefits to Nancy Smith after her employer, Rehab, changed from one group health plan to another. The case was subsequently removed to this court. By the time it reached the summary judgment stage, only Rehab, Rehab's employee health care plan, and the plan's administrator, remained as Defendants, and Plaintiffs sought recovery from them under ERISA on claims of equitable estoppel, breach of fiduciary duty, and breach of contract. On April 16, 1992, this court granted summary judgment in favor of Defendants on all three claims. Addressing the equitable estoppel and breach of fiduciary duty claims, the court found that Plaintiffs had not established detrimental reliance upon misrepresentations made to them and, it followed, could not establish the injury necessary to those claims.

Plaintiffs appealed to the Third Circuit Court of Appeals, which affirmed this court's judgment on the breach of contract theory, but reversed and remanded for further findings with respect to the detrimental reliance and injury elements of Plaintiffs' equitable estoppel and breach of fiduciary duty claims. *Smith v. Hartford*, 6 F.3d at 137-142. The Third Circuit instructed this court to make findings of fact concerning when Nancy Smith left the employ of Rehab, and whether she could have converted her then-existing Blue Cross/Blue Shield group coverage to a direct-pay subscription, for purposes of establishing detrimental reliance and injury. The Third Circuit further instructed that if detrimental reliance and injury were found, a further determination must be made as to whether the extraordinary circumstances necessary to an estoppel claim under ERISA are present in this case.[2]

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[2] Although the Third Circuit focused its discussion of detrimental reliance upon Plaintiffs' equitable estoppel theory, the court believes that the Third Circuit intended to preserve the liability of the breach of fiduciary duty claim as well.

Following remand, this court issued a scheduling order allowing six months for factual discovery, and setting deadlines for dispositive motions and trial. At the close of the discovery period, Defendant filed a motion for summary judgment, primarily asserting that regardless of whether detrimental reliance and injury were found, Plaintiffs could not recover any damages, from Rehab, in light of the decision of the United States Supreme Court in *Mertens v. Hewitt Assoc.*, 508 U.S. __, 113 S.Ct. 2063 (1993). Defendant also urged that Rehab could not be held to be a fiduciary under ERISA. Shortly after Defendant filed the summary judgment motion, the Third Circuit issued a decision in *Curcio v. John Hancock Mut. Life Ins. Co.*, 33 F.3d 226 (3d Cir. 1994), which sparked considerable doubt about the merits of Defendant's claim that Rehab could not be held to be a fiduciary. In light of these developments, the parties and the court agreed to bifurcate the liability issue from the question of available damages, which Defendant continued to urge were unavailable in light of the Supreme Court's *Mertens* decision.

At the September 30, 1994, pretrial conference, the parties further agreed that the court could adjudicate the liability question, including any disputed issues of fact, on the documentary record. The parties then submitted documentary evidence on the liability issue and, it appears, agreed to its relevance and admissibility. Accordingly, the court will consider all of the documents submitted with the summary judgment motion and the additional documentation and dispose of the liability issue as in a nonjury trial. To the extent Defendants' motion for summary judgment remains viable, it relates only to the question of damages, and it has been stayed pending disposition of the liability issue.

Inasmuch as many of the facts pertinent to liability are undisputed, the parties stipulated to them, and they will be set forth herein as findings of fact. Additional findings of fact,

made in accordance with the Third Circuit's instructions and any other appropriate findings also will be set forth herein, and discussed in Section IV, *infra*.

III. Findings of Fact

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1. Plaintiff Nancy M. Smith is a former nurse's aide who was employed by Rehab Hospital of Mechanicsburg when she suffered a cerebral hemorrhage on August 27, 1985.

2. Plaintiff Joseph L. Smith is Nancy Smith's husband.

3. Nancy Smith's cerebral hemorrhage rendered her disabled in that she was and remains unable to work or care for herself unassisted.

4. Following her cerebral hemorrhage, Nancy Smith became a skilled nursing care patient at Seidle Memorial Hospital in Mechanicsburg, Pennsylvania, where she remains presently.

5. On the date of her disabling hemorrhage, Nancy Smith was a beneficiary of Rehab's group health care policy with Capitol [sic] Blue Cross and Pennsylvania Blue Shield.

6. Included in Rehab's Blue Cross/Blue Shield group health care policy (hereinafter BC/BS Plan) was a Major Medical Agreement, pursuant to which Nancy Smith was entitled to unlimited days of skilled nursing care and a maximum lifetime benefit of one million dollars.

7. In accordance with the terms of Rehab's BC/BS plan, Blue Cross/Blue Shield paid for Nancy Smith's skilled nursing care in Seidle Memorial without incident until December, 1986.

8. Sometime in November, 1986, Rehab's parent company gave formal directions to Rehab to institute a self-funded employee insurance plan.

9. Following its parent company's directive, Rehab immediately prepared to terminate the BC/BS Plan and to institute a self-funded plan entitled "P.I.A. Voluntary Employees Beneficiary Association Group Insurance Plan" (the "VEBA Plan").

10. The employees of Rehab were notified that they must decide within one week whether to enroll in the VEBA Plan or seek alternative coverage.

11. At the time that Rehab commenced efforts to change from the BC/ES Plan, Nancy Smith had an enforceable right to its lifetime maximum benefit of one million dollars in skilled nursing care, which had not been exhausted.

12. In the one week between the notification to employees and the deadline for their enrollment in the VEBA Plan, Rehab's director of personnel, Beverly North, held seminars to explain the transition and terms of the VEBA Plan to the employees.

13. Nancy Smith was disabled and not engaged in active work for Rehab when the preparations for the change to the VEBA Plan were commenced.

14. At the time Rehab began preparation to change to the VEBA Plan, Joseph Smith had been laid off from his employment as a truck driver for approximately one year.

15. Beverly North was given explanatory documents about the VEBA Plan and the impending change in employee benefits by the VEBA Plan's authorized Administrator (the P.I.A. Voluntary Employees Beneficiary Association Administrative Committee ("P.I.A. VEBA/AC")), which she disseminated to the employees at these seminars.

16. Among the documents disseminated by Beverly North was one entitled "Transition Provision."

17. The Transition Provision contained one paragraph suggesting that currently disabled employees would remain

covered by the prior plan, and another suggesting that benefits payments for currently disabled employees would be paid in the lesser of the amounts permitted by the prior and the new VEBA Plan.

18. Despite her disabled condition, Nancy Smith was treated as other Rehab employees in that she was sent notice of the anticipated change to the VEBA Plan and the employee seminars.

19. On December 3, 1986, Joseph Smith attended two of the employee seminars on behalf of his wife.

20. Beverly North gave those present at the December 3, 1986 seminar, including Joseph Smith, copies of the Transition Provision, among other documents.

21. On December 3, 1986, Joseph Smith questioned Beverly North in the seminars and in her office about the conflicting paragraphs of the Transition Provision and how Mrs. Smith would be covered if he enrolled her in the VEBA Plan.

22. Beverly North discussed the conflicting paragraphs of the Transition Provision with Joseph Smith and assured him that the VEBA Plan would provide Nancy Smith with the same benefits as the BC/BS Plan.

23. Based upon the assurances from Beverly North, Joseph Smith believed that if he enrolled Nancy Smith in the VEBA Plan, she would be entitled to the remainder of the one million dollar maximum skilled nursing care benefit that she was entitled to under the BC/BS Plan.

24. Based upon Beverly North's explanations of the Transition Provision, and the assurances that Nancy Smith's medical benefits would continue as they were under the BC/BS Plan, Joseph Smith made the election on December 6, 1986, to enroll his wife in the VEBA Plan.

25. Joseph Smith was not given a copy of the VEBA Plan or a program describing its features prior to making the election to enroll Nancy Smith in it.

26. In the first several months after Nancy Smith's enrollment in the VEBA Plan, it made no payments for her care at Seidle Memorial Hospital.

27. Joseph Smith promptly informed Beverly North and other VEBA Plan representatives on several occasions that the VEBA Plan had not paid Seidle Memorial, and asked for reassurance about its coverage of Nancy Smith's skilled nursing care.

28. Beverly North and other VEBA Plan representatives assured Joseph Smith repeatedly that the VEBA Plan's failure to make payments to Seidle Memorial was attributable to administrative delays, and that Nancy Smith's care at Seidle Memorial was covered by the VEBA Plan.

29. A VEBA Plan representative also told Seidle Memorial's billing supervisor that Nancy Smith had coverage and payments were forthcoming.

30. When the VEBA Plan was instituted, the Hartford Insurance Group was its initial designated third-party claims processing administrator.

31. Two Hartford Insurance Group claims processors told Joseph Smith that the Seidle Memorial bills would be paid by the VEBA Plan.

32. The VEBA Plan's skilled nursing care benefit was not equal to that provided under Rehab's BC/BS Plan but, to the contrary, was limited to a maximum of one hundred and eighty days of confined skilled nursing care, which limitation applied to preexisting conditions of new subscribers.

33. On August 26, 1987, which was approximately nine months after Nancy Smith's enrollment in the VEBA Plan, the

Hartford Insurance Group informed Joseph Smith that Nancy Smith's Seidle Memorial bills would not be paid by the VEBA Plan because it had a 180-day limitation on skilled nursing facility care, and Nancy Smith had exceeded that limit prior to her enrollment.

34. Joseph Smith promptly contacted Rehab Hospital and the Pennsylvania Department of Insurance and challenged the VEBA Plan's refusal to provide Nancy Smith as promised with a maximum lifetime skilled nursing care benefit of one million dollars.

35. The VEBA Plan Administrator acknowledged that the Transition Provision had created confusion regarding coverage and, therefore, authorized an extension of skilled nursing benefits to Nancy Smith up to and including April 7, 1988.

36. On February 22, 1988, a Hartford claims processor informed Joseph Smith that the VEBA Plan would provide Nancy Smith with coverage for skilled nursing care up until April 7, 1988.

37. Joseph Smith again objected to the VEBA Plan's refusal to provide the maximum lifetime skilled nursing care benefit of one million dollars as promised.

38. Hartford ultimately responded to Joseph Smith's continued objections with a final offer of skilled nursing care coverage up to June 15, 1989, in exchange for his release of the VEBA Plan from any further claims on behalf of Nancy Smith.

39. Joseph Smith rejected Hartford's final offer and filed the captioned action.

40. No payments have been made from the VEBA Plan for skilled nursing care provided to Nancy Smith by Seidle Memorial after April 7, 1988.

41. Nancy Smith remains a skilled nursing care patient at Seidle Memorial to date.

42. The statements made by Rehab through its personnel director, Beverly North, were material misrepresentations which were intended to induce Joseph Smith's belief that the VEBA Plan would provide the same skilled nursing care and other benefits as the BC/BC [sic] Plan.

43. The material misrepresentations made by Rehab through Beverly North were intended to and did in fact induce reliance by Joseph Smith upon a belief that the VEBA Plan would provide the same benefits as the BC/BC [sic] Plan.

44. Joseph Smith relied upon Rehab's material misrepresentations in making the decision to enroll Nancy Smith in the VEBA Plan.

45. Had Joseph Smith known that the VEBA Plan would not cover Nancy Smith's skilled nursing care in the same or to as a beneficial a degree as the BC/BS Plan, he would not have elected to enroll Nancy Smith in the VEBA Plan.

46. In assuming responsibility for explaining to employees the comparison in benefits supposedly available under the BC/BS and VEBA Plans for the purpose of inducing the employees' reliance in making decisions about VEBA Plan coverage, Rehab exercised discretionary responsibility and control in the administration of the VEBA Plan.

47. The BC/BS group policy in effect in late 1986 (defined as when Rehab began preparations to change and until it did change to the VEBA Plan) had a provision that permitted Rehab's group subscribers to convert to BC/BS Direct Pay Subscriptions upon leaving the employ of provision.

48. The BC/BS group policy in effect in late 1986 contained the following provision, set forth in a March 1985 explanation of benefits pamphlet entitled "Your Blue Cross and Blue Shield Benefits," which governed the right of em-

ployees to convert from the group policy to BC/BS Direct-Pay Subscription:

> If you leave the employ of the Hospital, due to termination of employment, layoff, disability or leave of absence, Blue/Cross, Blue Shield, and Major Medical coverage may be continued by converting to a Direct-Pay Subscription Agreement.

49. BC/BS conversion privilege in effect in late 1986 had to be exercised within thirty days of leaving employment with Rehab.

50. As of late 1986, the BC/BS group policy in effect had incorporated a September 7, 1984 "Comprehensive Contract Letter" and its attachments, which included a "Comprehensive Hospital Service Certificate," containing the following provisions:

> If coverage of a Subscriber is terminated solely because of leaving the employ of the Group while this Contract is in effect, he or she may apply directly within 30 days of the termination to Blue Cross for its standard Contract issued to direct payment Subscribers under its regulations and at its established charges. . . .
>
> ° ° °
>
> The conversion privilege is not available if the Group cancels coverage in favor of Group coverage by another insurer.
>
> ° ° °
>
> This contract supersedes all prior contracts existing between the parties.

51. A prior version of the limitation on the conversion privilege made conversion unavailable if the Group cancelled coverage in favor of Group Coverage by "another organiza-

tion," but it had been superseded as of September 7, 1984, by the version referring to "another insurer" as described in paragraph 50 of these findings of fact, above.

52. On or about November 27, 1985, Beverly North sent a letter to Joseph Smith advising him that Rehab had placed Nancy Smith on leave of absence and that she would be required to make monthly premium payments of $80.08 should she wish to continue her coverage under the Blue Cross/Blue Shield group health policy.

53. Although the November 27, 1985, letter stated that Nancy Smith would be required to make monthly premium payments to remain covered under the Blue Cross/Blue Shield policy, Rehab continued to pay 80% of her medical insurance premiums until at least November 30, 1986, and an unknown portion of her medical insurance premiums until December 31, 1992.

54. The November 27, 1985, letter from Beverly North did not terminate Nancy Smith from employment for purposes of her employment and employment benefits rights.

55. Rehab took no formal steps to separate Nancy Smith from employment until December 17, 1992, when its Director of Human Resources wrote to Joseph Smith stating that Nancy Smith had been separated from employment in September 1985.

56. For purposes of her employment benefits and other employment rights, Rehab treated Nancy Smith as an employee in all respects at least up to and including the time that Rehab changed to the VEBA Plan in December, 1986.

57. For purposes of her employment benefits rights and other employment rights, Nancy Smith remained an employee of Rehab at least up to and including the time that Rehab changed to the VEBA Plan in December, 1986.

58. The VEBA Plan is not "another insurer" within the meaning of the conversion provision in effect on late 1986.

59. The BC/BS Plan remained in effect when Rehab initiated preparations to change to the VEBA Plan.

60. When Joseph Smith learned of Rehab's intent to change to the VEBA Plan, Nancy Smith had a right to convert from the BC/BS group policy to BC/BS Direct Pay Subscription because: (1) the BC/BS Plan remained in effect when Rehab initiated preparations to change to the VEBA Plan; (2) Nancy Smith had not "left the employ" of Rehab when it initiated preparations to change to the VEBA Plan; and (3) the VEBA Plan was not "another insurer" for purposes of the conversion limitation, Nancy Smith had the right to terminate her employment and exercise her right to conversion to BC/BS Direct-Pay Subscription.

61. Had Joseph Smith known that the VEBA Plan would not cover Nancy Smith's skilled nursing care in the same or to as a beneficial a degree as the BC/BS Plan, he could have and would have formally terminated Nancy Smith's employment on her behalf and enrolled her as a BC/BS direct pay subscriber within thirty days and thereby retain the skilled nursing care coverage benefit to which she was entitled under the BC/BS Plan.

IV. Discussion

As a threshold matter, the court must dispose of the argument that the action against Rehab must fail because it cannot be held to be a fiduciary under ERISA. The court cannot accept Defendant's position on this point, as the Third Circuit has signalled its belief to the contrary. In *Curcio v. John Hancock Mut. Life Ins. Co.*, 33 F.3d 226, 233-35 (3d Cir. 1994),

the Third Circuit indicated that in this case it had held Rehab to the status of a fiduciary because of the assurances it made with respect to the VEBA Plan's coverage. Moreover, even if the Third Circuit had not made its holding clear, the facts and holdings of *Curcio* and *Bixler v. Central Pa. Teamsters Health & Welfare Fund,* 12 F.3d 1292 (3d Cir. 1993), would compel an independent finding at this juncture that Rehab was a fiduciary.

In *Curcio,* a hospital employer making [sic] inaccurate representations about the benefits available under a new employee benefits plan and the plaintiff's decedent sued when those benefits turned out to be unavailable. The Third Circuit held that the hospital acted as a fiduciary in making the misrepresentations and, further, held the hospital liable to the plaintiff for the misrepresented unpaid benefits under alternative theories of equitable estoppel and breach of fiduciary duty. *Id.* at 234-39.

Bixler also involved misrepresentations made by an employer to an employee's relative. In that case, the district court had granted summary judgment in favor of the employer and the benefits plan that had refused coverage, implicitly reasoning that ERISA did not provide a breach of fiduciary action to an individual beneficiary. The Third Circuit reversed and remanded as to the employer, indicating that the court could infer that the employer was acting as an administrator and, hence, a fiduciary from the fact that the employer sent out its own COBRA notices concerning the plan to its employees. The Third Circuit further instructed that if the employer was acting as a fiduciary, it had a duty to respond to the plaintiff's request for information about benefits with complete and accurate information that was material to the plaintiff's circumstances. *See Bixler,* 12 F.3d at 1302. Thus, an application of the reasoning of *Curcio* and *Bixler* to the instant case leads

to an independent finding that Rehab acted as a fiduciary for purposes of Plaintiffs' claims.

The court perceives no dispute as to whether the statements made by Beverly North constituted material misrepresentations. Accordingly, the court will not belabor the issue. As the Third Circuit instructed, this court's task upon remand was to determine: (1) whether Nancy Smith remained an employee at the time that Rehab commenced preparations to change from the BC/BS Plan to the VEBA Plan; (2) if so, whether she had a right to convert to direct-pay subscription in light of Rehab's change to the VEBA Plan; and (3) if the preceding two conditions were satisfied, whether the extraordinary circumstances necessary for the equitable estoppel claim were present in this case. The court finds in Plaintiffs' favor on all three of these issues, and so finds Rehab liable to Plaintiffs.

The question of whether Nancy Smith remained an employee despite her disability admits of no easy resolution. ERISA unhelpfully defines an employee as an "individual employed by an employer." 29 U.S.C. § 1002(6). Lacking meaningful guidance, the court conducted an extensive search for cases addressing the question of when a disabled person continues to occupy the status of employee. Finding no case law on point, the court turned to cases addressing the broader question of employee status under ERISA. In that regard, the Supreme Court has directed that the issue of whether a worker is an employee for purposes of ERISA must be determined by reference to common law agency principles traditionally applied to distinguish between independent contractors and employees. *See Nationwide Mut. Ins. Co. v. Darden*, ___ U.S. ___, 112 S.Ct. 1344 (1992). Included in the factors that weigh in favor of the determination of employee status are the duration of the relationship between the parties and whether the employer provides and pays for employee benefits. *Id.* at

1348. The Supreme Court further emphasized that no "shorthand formula or magic phrase" will supply the answer, and that "all of the incidents of the relationship must be assessed and weighed. . . ." *Id.* (citations omitted).

Looking for additional guidance, the court discovered that the United States Secretary of Health and Welfare has formulated an interpretation of employee which it uses in deciding whether Medicare shall be only a secondary payor for the health care claims of disabled individuals. *See Ridgeway v. Sullivan,* 804 F. Supp. 1536 (N.D. Ga. 1992). The Secretary's definition of employee explicitly recognizes that disabled persons are not usually working. The definition goes on to state that whether a disabled person continues to be an employee for purposes of insurance must be determined from the unique facts of the relationship with the employer, and depends ultimately upon whether the employer treats the disabled individual who is not working as an employee. *See Ridgeway,* 804 F. Supp. at 1538-39 & n. 2 (quoting 3 Medicare Carriers Manual, U.S. Dept. of Health and Human Services, HCFA-Pub. 14-3, at § 3337 (1988)). Among the factors to be considered are whether the individual participates in an employees benefits plan in which only employees may participate, and whether the employee has the right to return to work should his or her condition improve. *Id.*

Here, it is undisputed that Rehab continued to pay almost all of Nancy Smith's premiums after her disability, and well after the change to the VEBA Plan, and that the BC/BS and VEBA Plans were open only to employees. Furthermore, it appears to be undisputed that Nancy Smith would have had a right to return to work had her condition improved, even though it was an unlikely development. Even if the right to return to work were disputed, Rehab's failure to take formal steps to conclusively terminate Nancy's employee status, and its decision to place her on leave of absence rather than

terminate her, supports a finding that she retained the right to return to work if she were able, eventually. Moreover, Rehab's delivery to Nancy and Joseph Smith of documents addressed to or intended only for employees reveals its continued regard of Nancy as an employee. Accordingly, the court finds that Nancy Smith was an employee at the time that Rehab commenced preparations to change to the VEBA Plan.

The next question is whether despite Nancy Smith's employee status, she had the right of conversion to direct-pay BC/BS coverage. The issue is whether Rehab's impending cancellation of the BC/BS policy in late 1986 would have defeated Nancy Smith's right to convert, in light of the BC/BS' policy's denial of the conversion right when the Group cancels group coverage in favor of "another insurer," or "another organization." To arrive at that finding, the court first must determine which version of the BC/BS policy was in effect at the time preparations for the change to the VEBA Plan commenced: the version containing the phrase "another organization" or the version containing the phrase "another insurer."

The material submitted by the Parties included two sets of documentation. On the one hand, there are BC/BS policy documents dated February 1, 1984. The conversion limitation with the phrase "another organization" was contained in that set of documents. There was also the September 7, 1984 "Comprehensive Contract Letter" and its attachments, which, in turn, included a "Comprehensive Hospital Service Certificate" with the conversion limitation using the phrase "another insurer." The Certificate was issued, as noted, on September 7, 1984, but contained a notation that its initial term began on February 1, 1984, effectively. The Certificate contained a statement that its provisions superseded all other previously issued provisions of the policy, and further stated that it would remain in effect from year to year. There is no evidence that the Certificate was cancelled or superseded and, accordingly,

the court finds that the conversion limitation using the phrase "another insurer" remained in effect as of December 1986, when preparations for the change to the VEBA Plan were commenced.[3]

The court further finds that the VEBA Plan was not another insurer. The ordinary understanding of the term insurer does not warrant inclusion of a self-funded employee benefits plan. Furthermore, in construing ERISA's preemption, savings, and deemer clauses, 29 U.S.C. §§ 1144 (a), 1144 (b) (2) (A) and 1144 (b) (2) (B), and the power of states to regulate insurance in light of ERISA, the Supreme Court has held that self-insured ERISA plans may not be deemed to be insurance companies or "other insurers" for purposes of state laws that would seek to regulate these plans. *FMC Corp. v. Holliday*, 498 U.S. 52, 58-61 (1990). In any case, in its decision in the appeal of this matter, the Third Circuit indicated that were it presented with the issue, it would be hard-pressed to view the VEBA Plan as "another insurer." This court agrees, and so holds that the VEBA Plan was not another insurer within the meaning of the conversion limitation. Therefore, Nancy Smith had a right of conversion to a BC/BS direct-pay subscription that would have preserved her maximum $1,000,000 skilled nursing care benefit.

There is no dispute that had Joseph Smith been informed correctly of the unavailability of skilled nursing care benefits under the VEBA Plan, he would have exercised Nancy Smith's conversion right in her behalf. The only question remaining,

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3. Had this court not viewed the record as clear on which variation of the conversion limitations applied to Nancy Smith, this finding still would have been the same. In that event, the court would have heeded the Third Circuit's direction and applied the principle of *contra proferentum* to construe the policy documents in favor of the insured. *See Smith v. Hartford*, 6 F.3d at 139, n.9. In this case, *contra proferentum* would support a finding that the conversion limitation with the phrase "another insurer" applied to Nancy Smith.

therefore, is whether this combination of unfortunate developments rises to the level of extraordinary circumstances required for an equitable estoppel claim under ERISA. The court believes that this question has been effectively answered by the Third Circuit in the *Curcio* decision. There, the court found extraordinary circumstances on facts that appear far less compelling that [sic] those at bar.

In *Curcio,* a hospital misrepresented to its employee that he had secured certain accidental death benefits and, upon his death, reassured his widow that the benefits were available. The hospital encouraged the widow to file suit when the benefits were later denied, offered to pay her legal fees, and encouraged the insurer to provide the benefits. By comparison, Rehab made false misrepresentations in response to careful requests for guidance, causing Nancy Smith to relinquish BC/BS's essential and already vested skilled nursing care benefit. Rehab later made repeated assurances that the benefit would be provided. Indeed, Rehab's actions plainly demonstrate that it, too, believed in and supported Nancy Smith's entitlement to the requested benefit. Moreover, the VEBA Plan itself acknowledged the confusion and unfortunate result, and attempted to make amends by supplying some portion of the misrepresented coverage. On these facts, the court finds a compelling case for a finding of extraordinary circumstances.

Plaintiffs have satisfied all of the requirements for a judgment in their favor on the equitable estoppel claim. Following the lead of the Third Circuit in the *Curcio* decision, the court finds that it is a short step to conclude that Rehab breached its fiduciary duty to Nancy Smith. Therefore, Plaintiffs are also entitled to judgment in their favor on their alternative theory of breach of fiduciary duty.

III. Conclusions of Law

1. In assuming discretionary responsibility for explaining to Rehab employees the comparison of benefits available under the BC/BS and VEBA Plans for the purpose of assisting the employees in making the decision concerning VEBA Plan enrollment, Rehab acted as a fiduciary with respect to the VEBA Plan.

2. For purposes of her employment and employee benefits rights, Nancy Smith remained an employee of Rehab as of December 3, 1986.

3. The BC/BS policy in effect as of the time that Rehab commenced preparations to change to the VEBA Plan provided that the conversion privilege was not available if group coverage was cancelled in favor of another insurer.

4. The VEBA Plan was not "another insurer" for purposes of the BC/BS Plan's conversion privilege.

5. As of December 3, 1986, Nancy Smith had a right of conversion to BC/BS direct pay subscription coverage.

6. Had Joseph Smith known that the VEBA Plan would not cover Nancy Smith's skilled nursing care to the same or to as a beneficial a degree as the BC/BS Plan, he could have enrolled her in the BC/BS Plan and retained the maximum skilled nursing care benefit of $1,000,000.

7. The statements made by Beverly North to Joseph Smith concerning the benefits available to Nancy Smith under the VEBA Plan constituted material misrepresentations.

8. Joseph Smith believed and reasonably relied to his detriment upon the material misrepresentations made by Rehab through Beverly North.

9. The combined circumstances of Nancy Smith's condition, the favorable BC/BS benefits vested and available to her

at the time that Rehab initiated the change to the VEBA Plan, the availability to her of direct pay subscription to BC/BS, the ambiguous written materials provided by Rehab, the misinformation and false written and oral reassurances provided by Rehab to Joseph Smith both prior to and after the change to the VEBA Plan, constitute extraordinary circumstances for purposes of Plaintiffs' equitable estoppel claim.

10. The material misrepresentations made to Joseph Smith by Rehab through Beverly North, and the failure of Rehab to obtain correct information concerning the benefits available under the VEBA Plan in response to Joseph Smith's questions, constituted a breach of Rehab's fiduciary duty under ERISA.

11. Judgment will be granted in favor of Plaintiffs on the liability aspects of their equitable estoppel and breach of fiduciary claims against Rehab.

/s/SYLVIA H. RAMBO, Chief Judge
Middle District of Pennsylvania

Dated: February 16, 1995

Filed October 4, 1993

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 92-7310

NANCY M. SMITH and JOSEPH L. SMITH, her husband

v.

THE HARTFORD INSURANCE GROUP; THE PROVIDENT LIFE AND ACCIDENT INSURANCE GROUP; NATIONAL MEDICAL ENTERPRISES INC.; NATIONAL MEDICAL SPECIALTY HOSPITAL GROUP; PSYCHIATRIC INSTITUTES OF AMERICA HEALTH CARE GROUP; PENNSYLVANIA HEALTH CORP., d/b/a The Rehab Hospital in Mechanicsburg; P.I.A. VOLUNTARY EMPLOYEES BENEFICIARY ASSOCIATION GROUP INSURANCE PLAN; P.I.A. VOLUNTARY EMPLOYEES BENEFICIARY ASSOCIATION ADMINISTRATIVE COMMITTEE

Nancy M. Smith and Joseph L. Smith, Appellants

On Appeal from the United States District Court
for the Middle District of Pennsylvania

(D.C. Civil Action No. 90-01541)

Argued: January 8, 1993

Before: HUTCHINSON and SCIRICA, *Circuit Judges*
and STANDISH, *District Judge**

(Filed October 4, 1993)

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*The Honorable William L. Standish, United States District Judge for the Western District of Pennsylvania, sitting by designation.

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OPINION OF THE COURT

SCIRICA, *Circuit Judge.*

This is an action seeking health insurance coverage under the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1001-1461 (1988). Nancy Smith has required skilled nursing care since suffering a cerebral hemorrhage in August 1985. After her employer changed its group health policy to a self-insured plan, she enrolled in the new plan based on the employer's erroneous representations that she would receive the same level of nursing care coverage. When the plan stopped providing coverage, Nancy and Joseph Smith filed suit, alleging the employer's misrepresentations entitled them to relief under ERISA. The district court

granted summary judgment to defendants. We will affirm in part and reverse in part and remand.

I.

On August 27, 1985, Nancy Smith suffered a cerebral hemorrhage while working as a nurse's aide for the Rehab Hospital in Mechanicsburg, Pennsylvania. As a result, she required continuous care in a skilled nursing facility, and became a patient at Seidle Memorial Hospital in Mechanicsburg. At the time of her hemorrhage, Mrs. Smith was covered by the Rehab Hospital's group health insurance policy with Capital Blue Cross and Pennsylvania Blue Shield. The policy, which paid for skilled nursing care up to a maximum lifetime benefit of $1 million and did not limit coverage to a specific number of days, covered Ms. Smith's expenses.

On December 1, 1986, while Mrs. Smith was still receiving care at Seidle Memorial, the Rehab Hospital's parent company directed its subsidiary hospitals to switch their health care coverage to self-funded insurance plans. Accordingly, the Rehab Hospital replaced the Blue Cross/Blue Shield policy with such a plan, entitled the P.I.A. Voluntary Employees Beneficiary Association Plan (the "VEBA Plan" or "Plan"). Unlike the Blue Cross/Blue Shield policy, the VEBA Plan covers skilled nursing care only for the first 180 days of the patient's confinement.

Rehab Hospital employees received only one week to decide whether to enroll in the VEBA Plan. The Hospital's personnel director Beverly North conducted seminars to help employees make this decision. At the seminars, North distributed a one-page document entitled "Transition Provision," summarizing certain effects of the change in plans. This document provides in part:

WE WILL WAIVE OUR PRE-EXISTING CONDITION LIMIT FOR EVERYONE ENROLLED IN YOUR PRIOR PLAN AS OF 11/31/86

IF YOU OR YOUR DEPENDENTS ARE IN THE HOSPITAL OR DISABLED ON 12/1/86, BENEFIT PAYMENTS WILL BE THOSE OF YOUR PRIOR PLAN OR OUR PLAN, WHICHEVER IS LESS

IF YOU ARE CURRENTLY DISABLED AND RECEIVING BENEFITS UNDER YOUR CURRENT CARRIER, BENEFITS WILL CONTINUE TO BE PAID TO YOU UNDER THE PROVISIONS OF THAT POLICY, NOT OURS

Despite the apparent contradiction between the last two paragraphs, North interpreted the "Transition Provision" to mean that benefits under the new self-insured plan would be the same as, or better than, those under the Blue Cross/Blue Shield policy.

On December 3, 1986, Joseph Smith, on behalf of his wife, attended two of the seminars North conducted on the changes in benefits. North distributed the Transition Provision and advised those attending that their benefits would not change under the VEBA Plan. Concerned about his wife's benefits, Smith specifically asked North at the seminar and afterwards in her office what his wife's benefits would be under the VEBA Plan. Referring to the above-quoted paragraphs of the Transition Provision, North assured Smith his wife would receive exactly the same benefits under the VEBA Plan as under the Blue Cross/Blue Shield policy. Smith then elected to enroll his wife in the VEBA Plan.

When the VEBA Plan failed to make payments for Mrs. Smith's nursing care in the months following the Smiths' enrollment, Mr. Smith repeatedly contacted Plan repre-

sentatives to inquire about coverage. Each time these representatives told him not to worry and attributed the failure to pay Mrs. Smith's nursing care bills to administrative delays. Initially, Mr. Smith telephoned North several times asking how to obtain payment for his wife's bills. North told him to submit the bills to the Hartford Insurance Group, the VEBA Plan's processing agent. In January 1987, when payments were not forthcoming, Seidle Memorial's billing supervisor Sandra Fertenbaugh contacted the Rehab Hospital to inquire about coverage. Karen Davies, North's successor, advised Fertenbaugh that Smith was covered under the Plan. Apparently believing Hartford had simply replaced Blue Cross/Blue Shield as the group insurer, Mr. Smith telephoned Hartford several times. Two Hartford claims processors assured him his wife's bills would be paid, and attributed the Plan's failure to pay claims to the delay in receiving Mrs. Smith's medical records and the transition in plans. Despite these repeated assurances, Hartford sent Mr. Smith a letter on August 26, 1987, informing him his wife's skilled nursing benefit was exhausted because her stay in the skilled nursing facility had exceeded the 180-day limit under the VEBA Plan, and that no further payment would be made.

Mr. Smith promptly appealed the denial of benefits in a letter to the Rehab Hospital and a formal complaint to the Pennsylvania Department of Insurance, explaining he had enrolled his wife in the VEBA Plan based on assurances he received in the Transition Provision and from Ms. North and Hartford that his wife would continue to receive the same coverage for her nursing care expenses. Hartford responded by letter on February 22, 1988, stating the VEBA Plan would agree to pay for nursing care services though April 7, 1988. On December 6, Hartford reiterated to Mr. Smith no coverage would be provided for care given after April 7, only to receive further appeals from Mr. Smith. On July 14, 1989, Hartford

communicated the Plan's final offer—to extend coverage through June 15, 1989—if Mr. Smith would accept this as full and final payment. He rejected this offer. The Plan has not paid Mrs. Smith's expenses since April 7, 1988, although she remains a skilled nursing care patient at Seidle Memorial.

II.

On July 17, 1990, the Smiths brought suit to obtain the disputed coverage in the Court of Common Pleas of Cumberland County, Pennsylvania against Hartford and Provident Life and Accident Insurance Company, who replaced Hartford as the Plan's claim processor. Hartford and Provident removed the case to the United States District Court for the Middle District of Pennsylvania because the Smiths' claim was subject to ERISA, and moved to dismiss the complaint.[1] The Smiths amended their complaint, naming additional defendants, and all defendants moved unsuccessfully to dismiss this complaint. The parties stipulated to the dismissal of all defendants other than the Rehab Hospital, the VEBA Plan, and the Plan's Administrator, and the case proceeded against these parties.

In the district court, the Smiths claimed defendants' actions gave rise to ERISA liability under three theories. They contended the Transition Provision coupled with the Hospital's oral representations to them constituted an "employee welfare benefit plan" enforceable in a breach of contract action under § 502(a)(1)(B) of ERISA, 29 U.S.C. § 1132(a)(1)(B). The Smiths also maintained these representations formed the basis for an equitable estoppel claim under § 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3). Finally, they claimed the Hospital's actions constituted a breach of fiduciary duty running from the Plan and its Administrator to the Smiths, a claim

[1] ERISA's civil enforcement provision gives exclusive subject matter jurisdiction over such actions to federal district courts, 29 U.S.C. § 1132(e).

also actionable under § 502(a)(3). Defendants moved for summary judgment.

Granting the motion, the district court held the written and oral representations did not contain sufficiently specific information regarding benefits and eligibility to constitute an employee benefit plan enforceable under ERISA. The court also ruled the Smiths could not recover on their equitable estoppel claim because they could not show injury resulting from their reliance on the Hospital's misrepresentations. To establish injury, the Smiths maintained that were it not for the misrepresentations, they could have obtained alternative coverage. But the district court held the Smiths had not introduced sufficient evidence that such coverage was available to them to withstand summary judgment. The court also held the Smiths' inability to show injury justified dismissal of their claim for breach of fiduciary duty.[2] The Smiths appealed.

III.

A.

We have jurisdiction under 28 U.S.C. § 1291. We exercise plenary review over the district court's grant of summary judgment, which we can uphold only if there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. *Taylor v. Continental Group Change in Control Severance Pay Plan*, 933 F.2d 1227, 1231 (3d Cir. 1991); Fed. R. Civ. P. 56(c).

B.

ERISA grants the beneficiary of an "employee welfare benefit plan," 29 U.S.C. § 1002(a), an express contract action

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[2] The Smiths moved for reconsideration, asserting two new theories, a common law contract right to benefits, and a claim that the court's grant of summary judgment constituted an unconstitutional taking of their property. The district court denied the motion, ruling that since the Smiths produced no new evidence and did not establish an intervening change in the law, they could not assert these arguments for the first time on a motion to reconsider.

"to recover benefits due to him under the terms of his plan," 29 U.S.C. § 1132(a)(1)(B). The Smiths invoke this section, claiming the Transition Provision coupled with North's oral representations to Mr. Smith constitute an enforceable "employee welfare benefit plan."

ERISA does not define the critical term "plan." But we have ruled that a plan need not be written, *Deibler v. United Food & Comm. Workers' Local Union 23*, 973 F.2d 206, 209 (3d Cir. 1992), and we have adopted the test developed in *Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir. 1982) (en banc), to determine whether informal written or oral communications such as those alleged by the Smiths constitute a plan. *See Deibler*, 973 F.2d at 209, *Henglein v. Informal Plan For Plant Shutdown Benefits*, 974 F.2d 391, 399-400 (3d Cir. 1992). Under that test, "a court must determine whether from the surrounding circumstances a reasonable person could ascertain the intended benefits, a class of beneficiaries, the source of financing, and procedures for receiving benefits." *Donovan*, 688 F.2d at 1373. In *Donovan* a series of employers subscribed to a multiple employer trust which provided insurance through the purchase of commercial policies which themselves laid out details regarding benefits and eligibility. Additionally, there were participation agreements signed by employees and employers indicating who subscribed to the trust and making clear the subscribers financed the trust. 688 F.2d at 1373-74. The district court noted no such similar documents existed here. The court also observed that unlike the Transition Provision, which referred internally to a pre-existing plan, the Donovan trust did not replace an existing plan.

We agree the Hospital's oral and written representations did not constitute an informal plan. Construed in the light most favorable to the Smiths, the Transition Provision was an "act ... that record[ed]" a "decision to extend certain benefits." *Donovan*, 688 F.2d at 1373. Although *Donovan* stated such

acts can be "direct or circumstantial evidence" of a plan, they are not in themselves a plan. *Id.* Moreover, as the district court noted, the force of this evidence, and of the Smiths' claim, is undercut by the Transition Provision's reference to another pre-existing plan. Finally, the Transition Provision contains conflicting statements regarding two of the Donovan factors—the class of benefits and the class of beneficiaries. In one paragraph, it limits employees "disabled on 12/1/86" to benefits under the old plan or the new plan, whichever is less; in the following paragraph, It provides "currently disabled" employees with coverage under the old plan.[3]

Moreover, we believe characterization of the Transition Provision and the oral representations as a "plan" would be contrary to ERISA. As we pointed out in *Hozier v. Midwest Fasteners, Inc.*, 908 F.2d 1155 (3d Cir. 1990), ERISA does not require employers to establish benefit plans and does not subject welfare benefit plans to the vesting requirements it imposes on pension plans because "Congress ... balance[d] its desire to regulate extant plans more extensively against the danger that increased regulation would deter employers from creating such plans in the first place." *Id.* at 1160. Consistent with this concern, the Second Circuit has observed that a rule requiring "all communications between an employer and plan beneficiaries to be considered along with summary plan descriptions as establishing a plan," would diminish "[p]redicta-

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[3] Additionally, the Smiths' claim is significantly weaker than the claims in *Henglein* and *Deibler*, two recent cases in which we applied the *Donovan* test to informal plans. In *Deibler*, we found an informal union severance pay plan established by relying on the minutes of a union meeting stating the union's intent to institute severance payments of one week's salary for each year of service, and on the fact that four union officers applied for and received severance over a two-year period until the union terminated the policy. 973 F.2d at 210. In *Henglein*, we relied on similar company memoranda distributed over a period of years to vacate and remand a district court's judgment that no informal severance plan had been established. 974 F.2d at 401-02. The Smiths have offered no similar documentation of an informal plan here.

bility as to the extent of future obligations ... and [create] substantial disincentives for even offering such plans." *Moore v. Metropolitan Life Ins. Co.*, 856 F.2d 488, 492 (2d Cir. 1988). For these reasons, we believe the district court correctly concluded the oral representations and the Transition Provision did not constituted [sic] an "employee benefit plan" enforceable under § 502(a)(1)(B).[4]

C.

We turn next to the Smiths' claim that the representations give rise to an equitable estoppel claim under ERISA. Section 502(a)(3) of ERISA permits a beneficiary "to obtain ... appropriate equitable relief ... to redress [ERISA] violations or ... to enforce any provisions of [ERISA] or the terms of the plan." 29 U.S.C. § 1132(a)(3). We have held this section permits an ERISA beneficiary to recover benefits under an equitable estoppel theory, upon establishing a material representation, reasonable and detrimental reliance upon the representation, and "extraordinary circumstances." *Gridley v. Cleveland Pneumatic Co.*, 924 F.2d 1310, 1319 (3d Cir. 1991).

The district court assumed the Transition Provision and hospital personnel director North's oral assurances to Mr. Smith of continued coverage constituted actionable misrepresentations, and assumed Mr. Smith reasonably relied upon them. We agree with these assumptions, which defendants do

[4] The district court also held the oral representations and the Transition Provision did not constitute an informal plan because they failed to contain many of the twelve categories of information ERISA requires for a summary plan description, *see* 29 U.S.C. § 1022(b). It relied on our decision in *Gridley v. Cleveland Pneumatic Co.*, 924 F.2d 1310, 1315-18 (3d Cir.), *cert. denied*, 111 S.Ct. 2586 (1991), which employed a similar analysis to reject a claim for benefits. We do not believe Gridley necessarily controls because there we considered whether a summary plan description had been created, whereas here we consider the distinct question whether an informal plan was created. *See Gridley*, 924 F.2d at 1310. Accordingly, our cases in *Henglein* and *Deibler*, applying the Eleventh Circuit's *Donovan* test, provide the applicable precedents.

not dispute. But the court nonetheless rejected the Smiths' estoppel claim on the ground they had not created a genuine issue of material fact that they sustained injury as a result of the misrepresentations, i.e., that their reliance was detrimental.

To establish injury, the Smiths must show they could have obtained an alternative health insurance policy that provided coverage for Mrs. Smith's nursing care were it not for the Hospital's misrepresentations. In the district court, the Smiths advanced three theories of injury. They contended that absent the misrepresentations, (1) they could have converted to an individual Blue Cross/Blue Shield policy under the conversion provision of the Rehab Hospital's group policy, (2) they could have shopped for alternative coverage, or (3) Mr. Smith, who was unemployed at the time, could have looked for a job providing the necessary coverage.

The district court rejected the second and third theories on the ground the Smiths produced no evidence that they could have purchased alternative coverage. We agree the Smiths' conclusory allegations that they could have obtained alternative coverage, without more, were insufficient to withstand summary judgment. Fed. R. Civ. P. 56(e); *Equimark Commercial Fin. Co. v. C.I.T. Fin. Servs. Corp.*, 812 F.2d 141, 142 (3d Cir. 1987).

More substantial is the Smiths' contention that were it not for the Hospital's misrepresentations, they could have converted to an individual Blue Cross/Blue Shield policy in order to retain the skilled nursing care coverage provided by Blue Cross/Blue Shield. The district court recognized the group policy contained a conversion provision, but believed it inapplicable to the Smiths' situation.

To assess this determination, we look first to the terms of the Blue Cross/Blue Shield policy. The policy provides in part:

> If you leave the employ of the Hospital, due to termination of employment, layoff, disability or leave of absence, Blue Cross/Blue Shield, Blue Shield and Major Medical coverage may be continued by converting to a Direct-Pay Subscription Agreement.[5]

The policy also provides that a subscriber entitled to conversion must exercise this right within thirty days of leaving the employ. A separate clause of the policy provides: "[t]he conversion privilege is not available if the Group cancels coverage in favor of group coverage by another organization," and what appears to be a subsequent version of that clause states: "[t]he conversion privilege is not available if the Group cancels coverage in favor of Group coverage by another insurer."[6]

These provisions reveal that the Smiths' conversion right, and hence their equitable estoppel claim, hinges on two critical questions: when Mrs. Smith left "the employ" of the Rehab Hospital, and, assuming she did not leave "the employ" of the Hospital until the time it switched plans, whether she was nonetheless barred from converting because the Hospital's change to the self-insured VEBA Plan constituted group coverage "by another organization" or "by another insurer."

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5. Neither party has been able to produce a copy of the policy in effect on August 27, 1985, and therefore the provision set forth in the text is drawn from a March 1985 "explanation of benefits" pamphlet Blue Cross/Blue Shield issued to the Rehab Hospital subscribers. App. 809. The parties agree this provision contains the operative language regarding whether Nancy Smith was in the employ.

6. Because the second version of the policy contains a clause stating the policy "supersedes all prior contracts existing between the parties," we would ordinarily conclude the operative phrase is the term "another insurer" rather than "another organization." But the record is in such a state that we are unable to determine whether the policy containing the words "another insurer" is in fact a later version of the policy. The version of the policy using the phrase "another organization," App. 781, appears to bear the effective date February 1, 1984, App. 775, while the version of the policy using the phrase "another insurer," Supp. App. 54, appears to be an attachment to a revision of that contract dated September 7, 1984, Supp. App. 42. Accordingly, we will analyze the effect of both versions of this clause on the Smiths' claim.

The district court focused only on the second of these questions, ruling the Smiths could not have converted to an individual policy because "the occasion for Smith's loss of Blue Cross/Blue Shield coverage was not that she left the employ of the Rehab Hospital due to disability," but "that her former plan was cancelled in favor of another." Defendants contend alternatively that Mrs. Smith left the "employ" upon becoming disabled in August 1985, and that her conversion right expired thirty days later. The Smiths maintain Nancy Smith remained in the "employ" until at least December 3, 1986 and that the VEBA Plan did not constitute a plan of "another organization" or "another insurer" within the meaning of the policy.

As we read the policy, the Smiths must prevail on both grounds to obtain coverage because the two conditions operate independently; a person is barred from converting either if she has left the employ and the thirty-day conversion period has elapsed, or if she has remained in the employ and the employer opts for coverage by "another organization" or "another insurer." Resolution of this dispute therefore turns on the proper interpretation of the term "the employ" and the phrases "another organization" and "another insurer."

(1)

We consider first the meaning of the term "the employ." We do not share defendants' apparent certitude about the meaning of this term. Neither the Blue Cross/Blue Shield Pamphlet nor the Summary Plan Description nor any other plan document in the record defines "the employ." Nor does the conversion provision state that an employee such as Mrs. Smith who suffers a "disability" automatically leaves the employ. It provides that a disability is one of four events, along with termination, layoff, or leave of absence, that can be the basis for leaving the employ. But it does not provide that occurrence of one of these events necessarily causes one to

leave the employ. Nor do these events help us define "the employ" because they do not fall neatly into one category. A leave of absence is typically temporary, a layoff or a disability can be either temporary or permanent, and a termination is permanent.

We believe the term "the employ" is ambiguous. It could either refer only to active workers, as defendants apparently believe, or include certain disabled workers who continue to receive benefits, as the Smiths contend. In contending Mrs. Smith left the employ at or about the time of the disability, defendants urge us to conclude that only active workers are in "the employ." The Smiths disagree, maintaining she remained in "the employ" at the time the Hospital changed plans on December 1, 1986.

To choose between these competing meanings, we can consider extrinsic evidence of the parties' understanding of that term. *Taylor v. Continental Group Change in Control Severance Pay Plan*, 933 F.2d 1227, 1232 (3d Cir. 1991). An important source of such evidence is the parties' performance of the agreement. *Langer v. Monarch Life Ins.* Co., 879 F.2d 75, 81 (3d Cir. 1989). Evidence of the parties' performance can also demonstrate a latent ambiguity in the contract, *id.*, which itself is a basis upon which to deny summary judgment. *Taylor*, 933 F.2d at 1232 (reversing summary judgment in light of ambiguous ERISA plan provision).

The record contains abundant evidence that, even after Mrs. Smith suffered the cerebral hemorrhage, the Hospital treated her in important respects as an employee. It is undisputed the Hospital continued to pay Mrs. Smith's health insurance premiums—and Blue Cross/Blue Shield continued to provide her with coverage—until the Hospital switched plans on December 1, 1986, when it offered her the opportunity to enroll in its self-insured plan. Indeed, the Hospital

continued to provide coverage to Mrs. Smith under the VEBA Plan until April 7, 1988.

As a general matter, an individual's receipt of fringe benefits can be evidence of his status as an active employee. *De Jesus v. General Motors Acceptance Corp.*, 645 F. Supp. 146, 149 (D.P.R. 1986) (granting summary judgment to employee in ERISA action by relying on evidence he received sick leave benefits in support of finding he was "at work" within the meaning of benefits plan). Moreover, only employees were eligible for coverage under both the Blue Cross/Blue Shield Policy, App. 760-61, and the VEBA Plan, App. 507, 822. Indeed, the representations forming the basis for this lawsuit were made to Joseph Smith at a seminar held for employees regarding the change in coverage.[7]

Defendants maintain there is no evidence that the Smiths could have relied on the Hospital's continued payment of benefits because the Blue Cross/Blue Shield pamphlet "specifically and unambiguously advised Mrs. Smith of her right to convert coverage if she left the employ of the Hospital due to 'termination of employment' or 'disability.' " But this contention assumes "the employ" unambiguously refers to active workers, an interpretation we do not believe can be established at this point as a matter of law. Defendants also ignore the Hospital's persistent course of conduct between August 1985 and December 1986, when it continued to pay the Smiths'

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[7] Additional documentary evidence of Smith's continued status as an employee after her hemorrhage appears in Exhibit J to her Second Amended Complaint, a memo dated November 8, 1989. App. 44. The Smiths' receipt of this memo, coupled with the fact it was addressed only to "Employees with Hartford Medical/Dental Coverage," suggests she remained an employee as late as November 1989. Additionally, Exhibit 5 to Rehab Hospital Administrative Committee member Sandra Smith's deposition, a handwritten memo from Smith to Hartford Claims Processor Sharon Downs. dated November 17, 1987, refers to Nancy Smith as an "employee." App. 357.

health insurance premiums and re-enrolled her in its new plan, which supports the Smiths' interpretation of "the employ."[8]

Accordingly, we believe a factfinder could find Mrs. Smith remained in the employ of the Hospital until December 3, 1986, the date she enrolled in the VEBA Plan.[9] It could also find the Smiths reasonably and detrimentally relied on the Hospital's continued payment of their insurance premiums

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[8] We do not, as the dissent suggests, "hold[ ] alternately that [the Hospital's] acts may give rise to the extraordinary circumstances" required for an estoppel claim typescript at 24. Rather, the Hospital's acts, as evidence of a party's performance of a contract, aid in our interpretation of the meaning of the contractual term "the employ," which in turn determines whether the Smiths can establish the injury necessary for their estoppel claim

Additionally, we note the policy provides skilled nursing care coverage up to $1 million. Because only employees are eligible for coverage, the policy contemplates some individuals remain in "the employ" despite incurring $1 million in skilled nursing care—more than Mrs. Smith received during the fifteen months she was covered by the Blue Cross/Blue Shield policy.

[9] Adopting the Smiths' broader interpretation of "the employ" would comport with the principle of *contra proferentum*, under which courts construe ambiguous terms in insurance policies in favor of the insured. We recently joined several other circuits in adopting *contra proferentum* as a federal common law rule in ERISA insurance cases. *Heasley v. Belden & Blake Corp.*, No. 92-3681, F.3d , 993 WL 284519, at *7-*8 (3d Cir. July 30, 1993) (citing cases from other circuits). As we explained in *Heasley*, *contra proferentum* recognizes insurance policies " 'are almost always drafted by specialists employed by the insurer, [who] should be expected to set forth any limitations on its liability clearly enough for a common layperson to understand; if it falls to do this, it should not be allowed to take advantage of the very ambiguities that it could have prevented with greater diligence.' " *Heasley* at *7 (quoting *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534, 540 (9th Cir.), *cert. denied*, 498 U.S. 1013 (1990)). Additionally, "[t]his reasoning is especially convincing where ... an insured employee seeks contractual benefits under ERISA, a statute designed to protect the interests of such employees." *Id.* These rationales apply here as well. But we do not believe it appropriate to employ *contra proferentum* to decide this case in the Smiths' favor at this time because that doctrine should be used only if normal principles of contract construction are unavailing. *Heasley* at *7. Consideration of extrinsic evidence to resolve ambiguities is one such principle. And we believe it appropriate for the district court in the first instance to weigh the extrinsic evidence here.

rather than seeking other insurance that would cover Mrs. Smith's skilled nursing care.[10]

We cannot agree with the dissent's conclusion that, as a matter of law, Mrs. Smith could not have been in "the employ" after suffering her hemorrhage in August 1985. The dissent concedes " 'the employ' ... is broad enough to cover some inactive participants along with active employees," but insists Mrs. Smith is not one of the covered "inactive participants." We recognize the policy could have been drafted to terminate coverage, and thereby trigger the thirty-day conversion right, whenever an employee suffers a disability which leaves her with no prospect of reemployment. But given the ambiguous policy language and the considerable evidence supporting the conclusion that the Hospital believed Mrs. Smith remained in "the employ" after her hemorrhage, we believe the dissent's construction runs afoul of accepted principles of insurance contract interpretation, ERISA's pro-worker underpinning, and our obligation to reverse summary judgment where there

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[10] The Smiths' estoppel claim, and particularly the reasonableness of their reliance, became especially compelling after June 1986, when the Plan incorporated the newly-enacted Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) amendments to ERISA, 29 U.S.C. §§ 1161-68 (1988). These amendments, adopted out of "concern[ ] with reports of the growing number of Americans without any health insurance coverage and the decreasing willingness of our Nation's hospitals to provide care to those who cannot afford to pay." H.R. Rep. No. 241, 99th Cong., 2d Sess. 44, *reprinted in* 1986 U.S. Code Cong. & Admin. News 579, 622, require private employers who offer group health insurance plans to notify employees in advance of any loss of health coverage due to any of several qualifying events, including termination of employment or disability. 29 U.S.C. § 1163(2), (4). The dissent's observation that our decision grants relief "beyond COBRA" because COBRA requires only eighteen months of continued group coverage after termination of employment is beside the point. COBRA does not purport to be the exclusive source of relief for employees seeking coverage. In particular, nothing in COBRA indicates it has displaced the federal common law equitable estoppel claim under ERISA, a claim we recognized both before COBRA's enactment, *Rosen v. Hotel & Restaurant Employees & Bartenders Union*, 637 F.2d 592, 598 (3d Cir. 1981), *cert. denied*, 454 U.S. 898 (1981), and since COBRA's enactment, *Hozier*, 908 F.2d at 1165 n.10.

is a genuine issue of material fact, Fed. R. Civ. P. 56(c), and to draw all inferences in favor of the non-movant. *J.F. Feeser, Inc. v. Serv-A-Portion, Inc.*, 909 F.2d 1524, 1531 (3d Cir. 1990), *cert. denied*, 111 S. Ct. 1313 (1991). Thus, our recognition of the Smiths' estoppel claim is not an effort to "amend" a plan outside the scope of § 502(a)(3) of ERISA.[11]

(2)

Even assuming Mrs. Smith remained in the employ at the time of the changeover in plans, she might still have been barred from converting if the Hospital's switch to the VEBA Plan constituted group coverage "by another organization" or "by another insurer." Again, the policy does not define the operative phrases "another organization" or "another insurer." The district court apparently believed any other insurance arrangement entered into by the Hospital would fall within these terms, as it rejected the Smiths' claim for the sole reason "that [Mrs. Smith's] former plan was cancelled in favor of another." But we believe it is not clear that a change in coverage to a self-insured plan constitutes coverage by "another organization" and find it even less likely that such a change could qualify as coverage by "another insurer."

Because these phrases are ambiguous, two questions must be explored on remand. First, which of the two versions of the policy—the one containing the words "another organization" or the one containing the words "another insurer"—was in force in December 1986, the time when the Smiths

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11. In concluding Mrs. Smith could not have been in "the employ" after her hemorrhage, the dissent focuses chiefly on Mr. Smith's deposition testimony that Mrs. Smith did not return to work after her hemorrhage, an undisputed fact. But this testimony, without more, is not an admission that Mrs. Smith's medical condition "negated an employment relationship at any time after her injury." Dissent typescript at 23. Mr. Smith's testimony does not represent a legal opinion on the proper interpretation and application of the policy. At most, the testimony, coupled with evidence of the Hospital's acts, creates a dispute of fact to be resolved at trial.

contend their conversion right attached. Second, what is the meaning of the applicable phrase—"another organization" or "another insurer."

The ambiguities in the terms of the Blue Cross/Blue Shield policy and the other facts of this case underscore the advisability for employers to provide full and timely disclosure of their plans via Summary Plan Descriptions. Such disclosure would further ERISA's stated policy "to protect ... the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto. ..." 29 U.S.C. § 1001(b). Prompt and accurate disclosure of the terms of the VEBA Plan to the Smiths could have prevented this dispute.[12] Were we to construe these ambiguous terms against the Smiths on summary judgment absent such disclosure, we would be holding an insured to constructive knowledge of an insurer's unfavorable post-hoc interpretation of the insured's rights. Such a result would frustrate accepted principles of insurance contract interpretation and the central goals of ERISA.

For these reasons, we will reverse the district court's grant of summary judgment in favor of the Hospital on the Smiths' estoppel claim, and remand for further proceedings on this claim. We will affirm summary judgment for the remaining defendants.[13]

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[12] We note that neither the Hospital nor the Plan Administrator gave the Smiths a copy of the summary plan description of the VEBA Plan or a copy of the Plan itself until four or five months after they enrolled. This violated ERISA's requirement that plan administrators must furnish "a copy of the summary plan description" to plan participants within ninety days. 29 U.S.C. § 1024(b)(1)(A).

[13] We reverse only as to the Hospital because the Smiths assert rights under the old Blue Cross/Blue Shield Plan rather than under the new VEBA Plan, and because the critical misrepresentations—the oral misrepresentations made by North in December 1986—were made to Mr. Smith by employees of the Rehab Hospital rather than the VEBA Plan or its Administrative Committee, who are the

IV.

To summarize, there are two principal questions on remand: when Nancy Smith left "the employ" of the Hospital, and whether the Hospital's change to the self-insured VEBA Plan constituted group coverage by "another organization" or "another insurer." Relevant to determining when Smith left the Hospital's "employ" are the effect of the Hospital's continued payment of Mrs. Smith's health insurance premiums, as well as whether the Hospital believed she remained in the employ although she was not then working. Whatever the Hospital's belief, it must be weighed against the Smiths' reasonable understanding of the term "the employ" Where, as here, "it does not appear that the [VEBA Plan] was the product of explicit bargaining, ... the reasonable understanding of the

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remaining defendants. Although we recognize the Hospital cannot be liable under ERISA simply by virtue of its status as Mrs. Smith's employer or its decision to change plans, *Payonk v. HMW Industries, Inc.*, 883 F.2d 221, 225 (3d Cir. 1989), it can be liable to the extent it acted as a fiduciary of the plan, *Fischer v. Philadelphia Elec. Co.*, 994 F.2d 130, 133-34 (3d Cir. 1993). In *Fischer*, we held an employer can be liable under ERISA in his fiduciary capacity both on breach of fiduciary duty and equitable estoppel theories for affirmative misrepresentations such as those made by North here. *See also Eddy v. Colonial Life Ins. Co. of America*, 919 F.2d 747, 750-51 (D.C. Cir. 1990) (misrepresentation to employee requiring conversion rights under health insurance plan gives rise to breach of fiduciary duty claim under ERISA). ERISA broadly defines a fiduciary as any person who "exercises any discretionary authority or discretionary control respecting management of such plan ... or has any discretionary authority ... in the responsibility in the administration of the plan." 29 U.S.C. § 1002(21)(A). We believe, in the circumstances of this case, the Hospital acted as a fiduciary of the VEBA Plan, and that in this capacity, it can be liable on an equitable estoppel claim under § 502(a)(3). We do not believe this case implicates concerns regarding the actuarial soundness of an ERISA plan that have discouraged courts from recognizing estoppel claims, because we hold the employer, not the Plan, is liable, and the employer need not satisfy any liabilities out of the Plan. *Bogue v. Ampex Corp.*, 750 F. Supp. 424, 430 (N.D. Cal. 1990) (recognizing estoppel claim "because recovery against the employer who is not the administrator would not diminish the fund"), *aff'd*, 976 F.2d 1319 (9th Cir. 1992), *cert. denied*, 113 S. Ct 1847 (1993). Nor do we believe the self-funded nature of the Plan should be a basis to allow the employer to avoid liability.

beneficiaries, as well as the intent of the employer, may be admissible to clarify ambiguities." Taylor, 933 F.2d at 1232 (finding such evidence admissible to define term "successor" in severance pay agreement). *Cf. Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534, 540 (9th Cir. 1990) (adopting *contra proferentum* in ERISA cases because insurance policies "are almost always drafted by specialists employed by the insurer"), *cert. denied*, 498 U.S. 1013 (1990). A similar inquiry will help determine the Hospital's intent regarding the phrase "another organization" or the phrase "another insurer"—depending on which of the versions of the policy is determined to have been in force in December 1986—and the Smiths' reasonable understanding of the relevant phrase, to determine whether the self-insured VEBA Plan fell within that phrase.

In the event the Smiths did have a conversion right and therefore suffered injury in reliance on the Hospital's representations, they also must establish the "extraordinary circumstances" necessary for an estoppel claim. *Rosen v. Hotel and Restaurant Employees & Bartenders Union*, 637 F.2d 592, 598 (3d Cir.) (finding such circumstances established), *cert. denied*, 454 U.S. 898 (1981). On the record before us, we believe a factfinder could find such circumstances are established, in light of the Hospital's repeated oral and written misrepresentations to Joseph Smith, his diligence in attempting to obtain accurate answers regarding his wife's coverage, as evidenced by his persistent questioning of Ms. North and Hartford Insurance personnel, and the immense coverage expenses at stake. We recognize of course that additional facts may be developed and we take no position on the ultimate determination.

V.

For the foregoing reasons, the order of the district court is affirmed in part and reversed in part and remanded.

HUTCHINSON, J., *Dissenting.*

I agree with the reasoning of the Court in Parts I, II and III A. and B. of its opinion, but I disagree with Part III C. and respectfully dissent from its order vacating the district court's grant of summary judgment in favor of the Rehab Hospital. To reach that decision, the Court, in Part III C. of its opinion, relies on the Smiths' theory that § 502(a)(3) of ERISA applies to this case and may permit them to recover on a theory of equitable estoppel. Section 502(a)(3) provides:

> (a) *Persons empowered to bring a civil action.* A civil action may be brought—
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> ...
>
> (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan ... .

29 U.S.C.A. § 1132(a)(3) (West 1985). I believe § 502(a)(3) has no application to this case because the Smiths seek to modify or amend the Plan, not to enforce it. Moreover, even if the statute did permit the use of equitable estoppel for the purpose of changing the terms of a plan, I believe that the Smiths have not pointed to any evidence in this record that would show all the traditional common law elements of equitable estoppel let alone the extraordinary circumstances this Court has previously indicated ERISA requires. Therefore, I would affirm.

The Smiths base their estoppel theory on the Hospital's December 1986 misrepresentation that Mrs. Smith would receive the same extended coverage under the self-insured

group plan the Hospital was then about to adopt that she had been entitled to receive under the old Blue Cross/Blue Shield group plan so long as she was a person in the "employ of the group." The Court concludes that the word "employ" is so ambiguous that it includes a person who has been totally disabled and comatose, without any reasonable prospect of recovery, for a year and three months. This record shows beyond contradiction that it was apparent soon after Mrs. Smith suffered her stroke that she would never be able to return to work at the Hospital. I do not think the meaning of the word "employ" can be stretched that far. Proof of continuing employment is an essential element of the estoppel Mrs. Smith seeks to impose because the opportunity to convert to a direct pay subscription, the opportunity she claims to have lost, had to be made within thirty days of the time it became apparent that her disability would preclude her return to work under the old Blue Cross/Blue Shield plan.

I recognize that the phrase "the employ," as used in the old plan, is broad enough to cover some inactive participants along with active employees, but the abstract possibility that some disabled employees will recover and return to work does not create a genuine issue of material fact about Mrs. Smith's continued employment[1] for purposes of the Plan in December 1986 when the Hospital's misrepresentations about continued coverage were made to her husband.[2]

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[1] "Employed" is defined as "the act of doing a thing and the being under contract or orders to do it." Black's Law Dictionary 471 (5th ed. 1979). "Employment" us defined as "[a]ctivity in which person engages or is employed; normally, on a day-to-day basis." *Id.* "The state of fact of being employed; *esp.* that of serving an employer for wages." Oxford English Dictionary 129 n.2 (Compact ed. 1981). Because Mrs. Smith has no prospect of reemployment, she no longer meets any of these definitions.

[2] Similarly, the COBRA amendments with their requirement of express notice of termination do not help Mrs. Smith because she was no longer in "the employ of the group" when these amendments became effective on July 1, 1986, more than ten months after Mrs. Smith suffered her disabling stroke and could no

The Smiths never contended in the district court that Mrs. Smith was an employee at any time after her stroke. Mr. Smith admitted in his deposition that his wife's medical status negated an employment relationship at any time after her injury. When asked how long Mrs. Smith was "employed" by the Hospital, he responded, "until she was sick" and "she has not returned to employment" since. Appendix ("App.") at 604. When asked whether she continued to work at the time of the changeover in plans, one year and four months after suffering the stroke, he replied, "No, she was in a coma." *Id.* at 607. Mr. Smith also said he "believes her disability is permanent and that she will probably never be able to live at home." *Id.* at 190.

Accordingly, I am unable to see any genuine dispute of fact over whether Mrs. Smith was still in "the employ" of the Hospital when the December 1986 misrepresentations about coverage under the new self-insured plan were made. Unless the Hospital is also estopped from denying that Mrs. Smith was still in its employ in December 1986, its argument that the Smiths could not have detrimentally relied on Mrs. North's

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longer return to work. Because COBRA was not in effect when Mrs. Smith lost all prospect of returning to work, I think its notice and continuing coverage requirements are inapplicable to this case. If COBRA were applicable, it would have required not only notice of termination of employment but also continuing coverage for eighteen months for plan years beginning on or after July 1, 1986. 29 U.S.C.A. §§ 1161, 1162(2), 1163(2) (West Supp. 1993). The relief the Court grants Mrs. Smith on her estoppel theory goes beyond COBRA.

COBRA's notice requirement is not foreign to state case law on termination of health and accident insurance after disability occurs. *See Guardian Life Ins. Co. v. Zerance*, 479 A.2d 949, 953 (Pa. 1984) (clear provisions of termination clause in question were part of insurance contract and permitted termination of coverage, upon notice, after the covered disability was incurred, but only upon express notice). Unfortunately for Mrs. Smith, state law does not apply to the Hospital's self-insured plan. *See* 29 U.S.C.A. § 1144(a) (West 1985) (ERISA preempts all state laws relating to employee benefit plans); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983); *see also FMC Corp. v. Holliday*, 498 U.S. 52 (1990) (any state laws regulating insurance are preempted by ERISA for self-funded plans).

December 1986 misrepresentation about continuing coverage under the new self-insured plan defeats the Smiths' theory of equitable estoppel, even at common law. The misrepresentation Mrs. North made about continuing coverage under the new plan caused Mrs. Smith no harm. It was already much too late for her to take advantage of the opportunity to convert to direct payment that she contends she lost in reliance on Mrs. North's misrepresentation.

Recognizing this problem, the Court holds alternately that certain acts of the Hospital which indicated that Mrs. Smith was still in the employ of the group may give rise to the extraordinary circumstances we have said are necessary to create an equitable estoppel under § 502(a)(3) of ERISA. *See Hozier v. Midwest Fasteners, Inc.*, 908 F.2d 1155, 1165 n.10 (3d Cir. 1990). Those actions include: (1) the Hospital's failure to notify Mrs. Smith that she had been terminated; (2) its act of sending her a memo addressed to "Employees with Hartford Medical/Dental Coverage" on November 8, 1989, long after she became disabled; (3) the oral representations Mrs. North made at the December 1986 employee meeting which Mr. Smith attended; (4) the Hospital's act of furnishing Mr. Smith with a written Transition Provision that ambiguously stated in one provision that persons already receiving benefits under the old plan would not be adversely affected by conversion to the new plan but in another provision indicated that only the more restricted benefits of the new plan would be available, *see* App. at 35; and (5) the Hospital's continued remittance of group premiums to Blue Cross/Blue Shield on Mrs. Smith's behalf. Mrs. Smith, however, was only one participant in the Plan. Others had an interest. The misleading acts of the Hospital with respect to a single participant cannot adversely affect the other participants or define the meaning of the Plan for them.[3] Thus, because this is not a simple

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[3] Generally, liability under ERISA is imposed on the Plan itself. Here the Court holds that the employer, not the Plan, can be liable. Some cases have allowed

bilateral contract between two parties, the act that is perhaps most significant is the continued remittance of premiums to Blue Cross/Blue Shield on Mrs. Smith's behalf at group rates. This continued from the time of Mrs. Smith's stroke on August 27, 1985 until the Hospital's changeover to the new plan in December 1986. In *Hozier*, we recognized that continued acceptance of a participant's contributions to a benefit plan may be one of the extraordinary circumstances necessary to create an ERISA estoppel under § 502(a). *See Hozier*, 908 F.2d at 1165 n.10 (citing *Rosenn v. Hotel & Restaurant Employees & Bartenders Union*, 637 F.2d 592, 598 (3d Cir. 1981)). Continuing payment of premiums or contributions is an obvious necessity if the plan is to remain sound and the rights of other participants to remain secure. Still, I do not

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an ERISA action based on equitable estoppel against an employer reasoning it would not adversely affect the actuarial soundness of the fund. *See, e.g., Rodrigue*, 948 F.2d at 969; *P.I.A. Michigan City v. National Forges Radiator*, 789 F. Supp. 1421 (N.D. Ill. 1992); *Stenke v. Quanex Corp.*, 759 F. Supp. 1244 (E.D. Mich. 1991); *Bogue v. Ampex Corp.*, 750 F. Supp. 424 (N.D. Cal. 1990), *aff'd*, 976 F.2d 1319 (9th Cir. 1992), *cert. denied*, 113 S. Ct 1847 (1993). While the Plan has a fiduciary relation to the beneficiaries, the employer may not. Use of estoppel may blur that distinction. The cases that have imposed ERISA liability on an employer do not discuss the effect this imposition of liability may have on the ability of the employer to continue to finance the benefits it has promised under its self-insured plan.

In *Fischer v. Philadelphia Elec. Co.*, 994 F.2d 130, 133 (3d Cir. 1993), however, we held an employer could be liable under ERISA for misrepresenting to employee-participants of its self-insured retirement plan the fact that changes which could affect the timing of their decision to take early retirement were under serious consideration. Here, I think any actions of the Hospital in a fiduciary capacity are immaterial to any fiduciary duty it may have under § 502(a)(3) of ERISA not to make material misrepresentations to its employee-participants. First, I believe Mrs. Smith was no longer an employee-participant in the Plan when the Hospital's misrepresentations were made. Secondly, I do not believe she can demonstrate detrimental reliance. Finally, I note my belief that it is necessary to base any duty to avoid misrepresentation a construction of §502(a)(3) which does impose on an employer a fiduciary duty to its employees. I believe the court's decision here rests on that construction. Otherwise, direct imposition of liability on an employer based upon common law actions for fraud or deceit could raise preemption issues.

think the other acts Mrs. Smith relies on, even when coupled with the continued contributions, create an estoppel under ERISA § 502(a).

The benefits pamphlet and the Blue Cross/Blue Shield contract constitute the only evidence before us concerning the terms of the old Blue Cross/Blue Shield plan. The benefits pamphlet provides:

> *If you leave the employ of the Hospital due to* termination of employment, layoff, *disability* or leave of absence, Blue Cross, Blue Shield and Major Medical *coverage may be continued by converting to a Direct-Pay Subscription Agreement.*

App. at 809 (emphasis added). The Blue Cross/Blue Shield contract provides:

> 1. *If coverage of a Subscriber is terminated solely because of leaving the employ of the Group* while this Contract is in effect, he or she may apply directly *within 30 days of the termination* to Blue Cross for the applicable Contract issued to direct payment Subscribers under its regulations and at its established charges.

App. at 781 (emphasis added).

This is not a case like *Langer v. Monarch Life Insurance Co.*, 879 F.2d 75 (3d Cir. 1989), where ambiguous terms of an agreement are defined by the parties' course of conduct in carrying it out. As already stated, some abstract ambiguity about the status of a disabled person who has some likelihood of recovery as an employee participant in a benefit plan is not material to Mrs. Smith's case. Her disability was total and permanent from its onset.

Section 502(a)(3) states a court may use equitable principles to "enforce" the provisions of a plan.[4] Here, the use of

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[4] In *Hozier*, 908 F.2d at 1165 n.10, we merely noted the possibility of an estoppel in the presence of extraordinary circumstances. In *Gridley v. Cleveland*

equitable estoppel to preclude the Hospital from denying Mrs. Smith's continued employment would amend, rather than enforce, the provision of the old Blue Cross/Blue Shield benefit plan that required a participant who ceased to be in "the employ of the group" to convert to direct-pay within thirty days of termination "due to disability." *Cf. Rodrigue v. Western & Southern Life Ins. Co.*, 948 F.2d 969, 971 (5th Cir. 1991) (rejecting equitable estoppel based on oral representations because express terms of plan control); *Cummings v. Briggs & Stratton Retirement Plan*, 797 F.2d 383, 389 (7th Cir.), *cert. denied*, 479 U.S. 1008 (1986); *see also Straub v. Western Union Tel. Co.*, 851 F.2d 1262 (10th Cir. 1988); *Nachwalter v. Christie*, 805 F.2d 956 (11th Cir. 1986).

Even if equitable estoppel were available to modify the terms of this plan, at trial the Smiths would have the burden of showing all the necessary elements of an estoppel. Thus, the Hospital could not be estopped from denying Mrs. Smith's continued employment unless she has shown that she reasonably relied on the actions that she says caused her to believe she was still in the "employ of the group" in December 1986. There is no evidence in this record showing the Smiths can meet that burden.

Mr. Smith's assessment of his wife's prognosis immediately after she suffered her stroke in August 1985, coupled with the quoted language in the March 1985 explanatory

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Pneumatic Co., 924 F.2d 1310. 1319 (3d Cir. 1991), we set forth the requirements of equitable estoppel but concluded that it was there unnecessary to decide whether estoppel was available as a theory for recovery of benefits secured by ERISA because the common law requirement of detrimental reliance was not met. In *Rosen*, 637 F.2d at 598, we did permit a participant to estop a pension fund from denying benefits despite a plan provision mandating that certain contributions to the plan be made by the employer where the employee was allowed to make the employer's contributions himself. In *Hozier*, we recognized that *Rosen* "can be classified as one of the 'extraordinary circumstances' as outlined in [prior ERISA cases limiting the use of estoppel to extraordinary circumstances]." *Hozier*, 908 F.2d at 1165 n.10 (quoting *Rosen*, 637 F.2d at 598).

pamphlet Blue Cross/Blue Shield had issued to Rehab Hospital group members, advised the Smiths that Mrs. Smith's group benefits were in jeopardy and that she needed to take action within thirty days to retain coverage. The explanatory pamphlet put Mr. Smith on notice that his wife's group coverage ended when it became apparent that her disability permanently precluded her from returning to work.

There is no evidence of any inquiry by Mr. Smith, between August 1985 when his wife became ill and the day in December 1986 when he says Mrs. North misled him, about who authorized the payment of group premiums on his wife's behalf, or their source. There is likewise no evidence that Blue Cross/Blue Shield knew of Mrs. Smith's longstanding total disability. Unless the old plan's limited conversion privilege is meaningless, Blue Cross/Blue Shield was not obligated to continue benefits unless a timely conversion were made and the premiums applicable to an individual direct-pay plan were paid.[5] If Blue Cross/Blue Shield, the insurers under the old plan, were not obligated to continue Mrs. Smith's coverage at group rates, there does not seem to be any basis for supposing that it would have done so if it had been aware that Mrs. Smith was no longer a member of the group.

In any event, an estoppel grounded in reliance on continued group coverage in this case seems to me to amend, rather than enforce, the Hospital's old plan. Because the estoppel the Smiths seek to create eliminates the need to convert to direct-

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[5] Generally, premiums for individual plans are substantially higher than those for the individual participants in group plans. *See Local 217, Hotel & Restaurant Employees' Union v. MHM, Inc.*, 976 F.2d 805, 809 (2d Cir. 1992) (recognizing group rate is lower than individual rate and this is one of reasons COBRA group continuing coverage was enacted). The conversion requirement is not uncommon in group plans for employees. Of course, if the continuing premiums are beyond the independent means of the worker whose disability has cost him his income from employment, the insurer's promise to indemnify will be empty words in that worker's ears.

pay within thirty days of termination, and the evidence shows Mrs. Smith no longer could be considered an employee of the group, it is not among the purposes for which § 502(a)(3) authorizes courts to resort to equitable principles.

I am unable to close this dissent, however, without commenting on the impact that termination of the Blue Cross/Blue Shield extended care benefit has on the Smiths and others like them.[6] The feeling of unfairness is palpable. Hopefully, it will not be beyond the power of the courts and Congress to dispel that sense of injustice despite the limitations ERISA puts on the techniques the common law would employ to adjust rigid rules to particular situations. Logic may be the law's tool but its heart is justice, and the public's demand for concrete justice will not be contained by the straitjacket of inflexible rules. Thus, in any contract of insurance or indemnity, an insurer's ability to avoid performance after a risk becomes reality makes the promisor's covenant to indemnify the promisee against the risk illusory. *Cf. Armistead v. Vernitron Corp.*, 944 F.2d 1287, 1296 (6th Cir. 1991) (absent clause in agreement permitting plan's termination, court would not read one into the agreement because to do so would render illusory the employer's promise to provide after retirement insurance benefits).

An employer's promise to pay the cost of medical care for its employees is illusory if an employer can unilaterally eliminate or reduce benefits. The employer is then relieved of its promise of indemnity just when indemnity is most needed, and the employee in need of care is deprived of part of what he worked to get. For the employee, there is no *quid pro quo*. When benefits are thus reduced or snatched away, the promises those employees thought their employers had made to

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6. For some reason the record has not been fully developed on this point. The reader is, however, again reminded that Blue Cross/Blue Shield is not a party to this case.

them disappear. Some courts have, nevertheless, held that a self-insured employer can amend or terminate a benefits plan in a way that relieves an employer, in whole or in part, of its promise of indemnity to employees who have already suffered covered disabilities. *See, e.g., McGann v. H&H Music Co.*, 946 F.2d 401 (5th Cir. 1991) (allowing employer, in ERISA § 510 discrimination action, to reduce maximum welfare benefit for AIDS after participant became ill because ERISA does not vest rights in welfare benefit plans), *cert. denied*, 113 S. Ct. 482 (1992); *In re White Farm Equip. Co.*, 788 F.2d 1186, 1192-93 (6th Cir. 1986). The rationale of these decisions needs examination. Congress's intent of avoiding vesting of rights in benefit plans may deprive participants of rights under the law of property, but it is not necessarily inconsistent with the existence of rights under the law of contracts. Unfortunately, I think we are unable to reach or consider that issue in this case. Mrs. Smith did not raise the question whether benefits could be terminated after she became disabled until her motion for reconsideration of the district court's order granting summary judgment. Moreover, even if this question of whether the Hospital's promise to her was illusory had been raised earlier, or could be otherwise considered on this appeal, Mrs. Smith's failure to convert to direct-pay would still be likely to preclude recovery because her right to convert, though limited in time, would seem to take the promise of extended care out of the class of promises that are wholly illusory. The conversion requirement is common in both insured and self-insured group plans for health and disability, and the law has long tolerated provisions requiring persons covered by a group insurance policy to convert to direct pay within a limited time after they leave the group. *See Guardian*, 479 A.2d at 952. n.7.

The Smiths present a hard case. It is regrettable that neither this Court nor the district court has been able to address directly the illusory promise issue that a restrictive

change in an ERISA health care plan presents when a reduction in benefits incident to the adoption of a new plan is applied to disabled participants after they are already receiving benefits under the plan in existence when they became sick and disabled.

Nevertheless, I would affirm the district court's order granting summary judgment in favor of the Hospital because Mrs. Smith had lost her right to convert to direct-pay at the time of the changeover in plans.[7]

A True Copy:
Teste:

Clerk of the United States Court of Appeals
for the Third Circuit

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[7]. I agree with the Court that the district court should, if it determines that Mrs. Smith was still in the employ of the Hospital at the time of the changeover in plans or that the Hospital is estopped from denying this fact, reconsider its decision that no conversion privilege was available because the Blue Cross/Blue Shield group plan was canceled in favor of another. The district court, on remand, must resolve which version of the provision, as discussed typescript *supra* at 15, applies and what that provision means.

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

CIVIL ACTION NO. 1:CV-90-1541

NANCY M. SMITH and JOSEPH L. SMITH,
Her Husband, Plaintiffs

v.

THE HARTFORD INSURANCE GROUP; THE PROVIDENT LIFE AND ACCIDENT INSURANCE GROUP; NATIONAL MEDICAL SPECIALTY HOSPITAL GROUP; PSYCHIATRIC INSTITUTE OF AMERICA HEALTH CARE GROUP; and PENNSYLVANIA HEALTH CORP., d/b/a THE REHAB HOSPITAL OF MECHANICSBURG, Defendants

MEMORANDUM AND ORDER

Before the court is a motion for reconsideration by plaintiffs Nancy M. Smith and Joseph L. Smith, together with a response by defendants, and a reply by plaintiffs. Before addressing the motion, the court will set forth the standards applied to a motion for reconsideration.

I. LEGAL STANDARD.

A motion for reconsideration is considered a motion to alter or amend the judgment under Federal Rule of Civil Procedure 59(e). *Nichols v. Board of Trustees, Asbestos Workers Local 24 Pension Plan*, 835 F.2d 881, 887 (D.C. Cir. 1987). Such a motion is a mechanism of limited application. It is not a mechanism for an unsuccessful party " 'to rehash' the same arguments and facts previously presented." *Keyes v. National R.R. Passenger Corp.*, 766 F. Supp. 277, 280 (E.D. Pa. 1991).

See also Keene Corp. v. International Fidelity Ins. Co., 561 F. Supp. 656, 665 (N.D. Ill. 1982), *aff'd*, 736 F.2d 388 (7th Cir. 1984). Similarly, it is not a mechanism to give the parties a second bite at the apple by presenting their case under new theories not originally pursued. *See Grumman Aircraft Eng'g Corp. v. Renegotiation Bd.*, 482 F.2d 710, 721 (D.C. Cir. 1973), *rev'd on other grounds*, 421 U.S. 168 (1975); *Marshall v. Southeastern Pa. Transp. Auth.*, 587 F. Supp. 258, 264-65 (E.D. Pa. 1984); *Evans, Inc. v. Tiffany & Co.*, 416 F. Supp. 224, 244 (N.D. Ill. 1976). Instead, the function of such a motion is to correct manifest errors of law or fact or present evidence discovered since the submission of the issue to the court. *Harsco Corp. v. Zlotnicki*, 779 F.2d 906, 909 (3d Cir. 1985), *cert. denied*, 476 U.S. 1171 (1986); *Keene Corp.*, 561 F. Supp. at 665. Hence, unless new evidence has come to light which, had such evidence been discovered previously, could have affected a court's decisions, or unless the law on an issue has changed, or the court has made a clear legal or factual error, a motion for reconsideration will not be granted.

II. PLAINTIFFS' MOTION.

Plaintiffs' motion makes two arguments for reconsideration. One is that the Rehab Hospital had an employment contract with Nancy Smith under which she was entitled to Blue Cross insurance coverage and, that under contract law principles, Rehab could not change those health benefits. Plaintiff argues that since under such employment contracts and applicable contract law employers cannot change employee benefit plans at will, under ERISA the result should be no different.

The second argument is that since Nancy Smith had the above contractual entitlement to Blue Cross health insurance

benefits, any application of ERISA that would condone allowing the benefits to be changed is a taking under color of law in violation of the fifth amendment.

This court will make no comment on the merit of these arguments. What is important here is that, notwithstanding the rationalizations in plaintiffs' reply brief, neither argument was presented to this court on summary judgment, nor was any evidence or authority in support of either presented. Plaintiffs' previous arguments were that Smith was entitled to the benefits she sought because (1) certain verbal and written representations by Rehab and the PIA/VEBA plan administrators constituted an independent and enforceable ERISA plan in themselves, either legally or through equitable estoppel, that (2) those representations should be viewed as interpretations or modifications of the PIA/VEBA ERISA plan enforceable through equitable estoppel, or that (3) there was a breach of ERISA fiduciary duty by defendants Rehab and the PIA/VEBA plan administrators.

Given the above, it is clear that no new evidence is presented, nor is it argued that the law has changed on the issues. Plaintiffs have utilized their motion to raise what this court considers to be new theories not previously presented. This is an improper use of a motion for reconsideration by plaintiffs.

Accordingly, IT IS HEREBY ORDERED THAT plaintiffs' motion for reconsideration is DENIED.

/s/SYLVIA H. RAMBO
United States District Judge

Dated: June 2, 1992.

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

CIVIL ACTION NO. 1:CV-90-1541

NANCY M. SMITH and JOSEPH L. SMITH, Plaintiffs

v.

NME SPECIALTY HOSPITAL GROUP; PSYCHIATRIC INSTITUTES OF AMERICA, INC.; PENNSYLVANIA HEALTH CORP. d/b/a THE REHAB HOSPITAL IN MECHANICSBURG; P.I.A. VOLUNTARY EMPLOYEES BENEFICIARY ASSOCIATION GROUP INSURANCE PLAN; and P.I.A. VOLUNTARY EMPLOYEES BENEFICIARY ASSOCIATION ADMINISTRATIVE COMMITTEE, Defendants

MEMORANDUM

I. INTRODUCTION.

Before the court in this ERISA action is the defendants' motion for summary judgment which has been fully briefed.

The court wishes first to note that both The Hartford Insurance Group and The Provident Life and Accident Insurance Company have been voluntarily dismissed as defendants in this action.[1] Furthermore, in their response brief, plaintiffs agree with defendants that NME Specialty Hospital Group and Psychiatric Institutes of America, Inc. should also be dismissed as defendants in this action. (Plaintiffs' Brief at 8.) Accordingly, NME and Psychiatric Institutes will be deemed dismissed as parties.

Before progressing to a discussion on the merits of defendants' motion, the court will set forth the factual background

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1. See two Stipulations for Dismissal, both filed December 12, 1991 with the clerk of court.

in this action, as well as the legal standards for summary judgment on which it will rely.

II. FACTS.

The following facts are taken from the parties' briefs and statements of undisputed facts, and depositions. They are largely undisputed. Where the parties differ, or do not address the same facts, the difference or the source is noted.

Plaintiffs are Nancy M. Smith and her husband Joseph L. Smith. Ms. Smith was employed as a nurse's aide by defendant Rehab Hospital when on August 27, 1985, she suffered a cerebral hemorrhage. Since that time she has not returned to work: she remains a skilled care patient at Seidel Memorial Hospital in Mechanicsburg. Her husband believes her disability is permanent and that she will probably never be able to live at home. (Deposition of Joseph Smith ("J. Smith Deposition"), August 2, 1991 at 49.)

After her hospitalization for the hemorrhage, Ms. Smith required resident skilled nursing care, a service covered under the then-existing Rehab Hospital group health care policy with Blue Cross and Blue Shield. The Blue Cross/Blue Shield policy did not limit skilled nursing care facility coverage in terms of any particular time period covered, but it did have a maximum lifetime benefit of one million dollars. Pursuant to that policy, Blue Cross-Blue Shield paid incurred expenses for Ms. Smith's care in a skilled nursing facility. In late November, 1986, defendant Rehab Hospital's parent company decided to have all its subsidiary hospitals change to a self-funded plan. It was decided to terminate the Rehab Hospital's Blue Cross-Blue Shield group plan in favor of the P.I.A. VEBA Plan,[2] a self-insured welfare benefit plan under ERISA. There was about one

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[2] Technically the plan's title was the P.I.A. Voluntary Employees Beneficiary Association Group Insurance Plan ("P.I.A. VEBA Plan").

week between the time the employees were notified about the change, and the deadline for enrollment in the new plan.

The administrator of the P.I.A. VEBA Plan was defendant P.I.A. Voluntary Employees Beneficiary Association Administrative Committee ("P.I.A. VEBA/AC"). The claims processor of the P.I.A. VEBA Plan was originally Hartford Insurance Group, and was later the Provident Life and Accident Insurance Company.

At the time of the changeover, Beverly North was director of personnel at the Rehab Hospital. The parties differ over exactly how to characterize her role, but she was apparently at least in charge of educating Rehab Hospital employees on the transition in health insurance. Both before and after the actual transition she was sent documents by the P.I.A. VEBA/AC to pass out to Rehab employees. Prior to the deadline for employees to enroll in the new health plan, North was sent a document to give to employees entitled "Transition Provision" which plaintiffs claim had been drafted by a member of the P.I.A. VEBA/AC, Narda Ehrlich.[3] In addition, Ms. North held a number of employee seminars on the insurance transition, at which a member of the P.I.A. VEBA/AC may have been present. (Deposition of Beverly North ("North Deposition"), September 17, 1991 at 13).

At the time of the transition, plaintiff's husband Joseph Smith had been laid off from his job as a truck driver for about a year. He kept abreast of developments at the Rehab Hospital because his wife was hospitalized there for some time, and a relative worked there. Mr. Smith attended two of the seminars

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3. Defendants contend that an employee of Specialty Hospital Group, an informal association of hospitals, drafted the document. However, Sandra Smith, a member of the P.I.A. VEBA/AC, testified that Ms. Ehrlich, an administrative committee member at the time, drafted it and that it would have been part of Smith's duties to review and approve it. (Deposition of Sandra Smith, September 5, 1991 ("Smith Deposition") at 27.)

held by Ms. North, where he received a copy of the "Transition Provision" document, and a booklet on cost saving. He claims he did not receive a copy of the P.I.A. VEBA health plan description or the plan until much later, four or five months after the transition. (Deposition of Joseph Smith ("J. Smith deposition") August 2, 1991 at 61).[4]

Mr. Smith was concerned about what his wife's benefits would be under the new plan. On a number of occasions, both at the seminars and in her office, he questioned Ms. North as to the "Transition Provision" and as to what Ms. Smith's coverage would be. North referred to the final paragraphs of the "Transition Provision" document and told him that Ms. Smith would receive exactly the same benefits as under the Blue Cross-Blue Shield Plan. (Defendants do not dispute this.) He then elected to enroll his wife in the new plan.

After the enrollment in early December, Joseph Smith testified that he spoke with North several times regarding what to do with his wife's bills. She told him to keep submitting them to Hartford Insurance, which he did. (J. Smith Deposition at 20-21.) In January 1987, Sandra Fertenbaugh, billing supervisor at the care facility treating Ms. Smith claims she contacted Karen Davies, North's successor as personnel director at the Rehab Hospital, and was told that Ms. Smith would be covered under the insurance plan with Hartford Insurance. (Letter from Sandra Fertenbaugh, Exhibit, Deposition of Karen Davies ("Davies Deposition"), August 7, 1991.)

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[4] While defendants do not directly contest this, one of the exhibits to the North deposition is a memo from Ms. North to "Eligible Insurance Subscribers" dated November 28, 1986, which states a deadline of December 5, 1986 for enrollment in the new plan, and urges them to carefully read "the Centralized Benefit Program binder, the Utilization Review brochure and the Pre-Tax Employee Premium Contribution Plan information." Neither Ms. North nor Ms. Davies, the subsequent personnel director, recalls exactly what material was given to employees. Mr. Smith does not mention this memo in deposition but claims he did not receive any program or plan.

Over the next months, Mr. Smith testified that he made telephone calls to Hartford Insurance (Smith apparently thought the new plan was actually a Hartford plan[5]) and was assured by Hartford claims processors Mr. Christian and Mr. Eakin that his wife's bills would be paid, but that the lack of medical records (which Mr. Smith had transferred three times) and the transition in plans was causing a delay. (*Id.* at 21.) None of the above individuals at the Rehab Hospital or at Hartford Insurance ever communicated to Mr. Smith that his wife's skilled care facility claims would not be paid.

On August 26, 1987, Mr. Smith was sent a letter from Mr. Christian denying payment for Ms. Smith's skilled care, because of the provisions of the Summary Plan Description of the P.I.A. VEBA Plan, which limited coverage for such care to 180 days. Ms. Smith had already exceeded this at the time of transition in plans. (Exhibit 3, J. Smith Deposition.)

On September 1, 1987, Mr. Smith appealed the decision to deny coverage. He discussed the terms of the "Transition Provision" document he had been given, how it had been explained to him by North, and how he was never given a copy of the plan or plan description till months after enrollment. (Exhibit 4, J. Smith Deposition.)

On February 22, 1988, a written response to Mr. Smith's appeal was sent to him by Hartford Insurance. It communicated an offer by the P.I.A. VEBA Plan to pay for skilled care services rendered to Ms. Smith through April 7, 1988, rather than adhering to the 180 day limit specified in the P.I.A. Plan. The offer was characterized as "an exception." (Exhibit 6, J. Smith Deposition). After a denial of post-April 7 coverage by

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5. The memorandum sent to potential subscribers by Beverly North on November 28, 1986 called the plan the National Specialty Hospital Group's Centralized Benefits Program, but referred to the need to fill out enrollment forms for "Hartford health, dental and life benefits" and employees' election "to participate in the Hartford health coverage." (Exhibit 1, North Deposition.)

Hartford (Exhibit 9, J. Smith Deposition), and several further appeals by Mr. Smith (Exhibits 7, 10, J. Smith deposition), the P.I.A. VEBA Plan authorized one final extension to pay all of Ms. Smith's costs through June 15, 1989, if Mr. Smith would accept this as full and final payment from the Plan. (Letter of S. Downs, Exhibit 11, J. Smith Deposition). Mr. Smith did not accept this offer, (Exhibit 12, J. Smith Deposition), and his wife's skilled care bills after April 7, 1988 have not been paid by the P.I.A. VEBA Plan.

II. LEGAL STANDARDS FOR SUMMARY JUDGMENT.

The court will consider defendants' motion under the accepted standards for the award of summary judgment under Rule 56 of the Federal Rules of Civil Procedure. The United States Court of Appeals for the Third Circuit has recently summarized those standards in a concise and helpful way:

> Summary judgment may be entered if "the pleadings, depositions[s], answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56 (c). An issue is "genuine" only if the evidence is such that a reasonable jury could return a verdict for the nonmoving party. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 106 S. Ct. 2505, 2510, 91 L.Ed. 2d 202 (1986); *Equimark Comm. Finance Co. v. C.I.T. Financial Serv. Corp.*, 812 F.2d 141, 144 (3d Cir. 1987). If evidence is "merely colorable" or "not significantly probative" summary judgment may be granted. *Anderson*, 106 S. Ct. at 2511; *Equimark*, 812 F.2d at 144. Where the record, taken as a whole, could not "lead a rational trier of fact to find for the nonmoving party, summary judgment is proper." *Matsushita Elec. Indus. Co. v. Ze-*

> *nith Radio*, 475 U.S. 574, 106 S. Ct. 1348, 1356, 89 L.Ed. 2d 538 (1986).

Hankins v. Temple Univ., 829 F.2d 437, 440 (3d Cir. 1987). The parties' burdens in summary judgment may be described in the following way: once the moving party has shown an absence of evidence to support the claims of the nonmoving party, the nonmoving party must do more than simply sit back and rest on the allegations in her complaint. She must "go beyond the pleadings and by her own affidavits, or by the 'depositions, answers to interrogatories, and admissions on file,' designate 'specific facts showing that there is a genuine issue for trial.' " *Celotex Corp. v. Catrett*, 477 U.S. 317, 324 (1986). If the nonmovant bears the burden of persuasion at trial,

> the party moving for summary judgment may meet its burden by showing that the evidentiary materials of record, if reduced to admissible evidence would be insufficient to carry the nonmovant's burden at trial.

Chipollini v. Spencer Gifts, Inc., 814 F.2d 893, 896 (3d Cir. 1987).

III. WHAT ARE THE WRITTEN PROVISIONS AND THE WRITTEN & ORAL REPRESENTATIONS AT ISSUE?

A. Written Provisions and Representations.

The written provisions and written representations at issue in this case are the transition terms of the Summary Plan Description[6] of the P.I.A. VEBA Plan and the provisions of the "Transition Provision" document given to employees before

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6. Under ERISA, each benefit plan must be established and maintained by a written "plan" instrument, which must fulfill certain content requirements. ERISA, § 402, 29 U.S.C. § 1102.

enrollment in the new plan. The relevant transition provisions contained in the actual Summary Plan Description of the Centralized Health plan administered by the P.I.A. VEBA/AC are the following:

> This section covers how benefits are determined when we replace a previous facility plan ("Prior Plan") with our Plan, such as in a new acquisition.
>
> If a Covered Person was covered by the Prior Plan on the day it canceled and would be covered by the Plan except that he cannot meet the requirements as stated on page 6 in this booklet then we will waive the Deferred Effective Date Provision. However, we will limit our coverage as follows:
>
> 1) We will not pay for any disability for which a benefit is payable under an Extension of Benefits Provision of the Prior Plan.
>
> 2) We will pay the lesser of the maximum benefit amount payable for any one disability or for any covered

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The plan must also furnish a plan description to the government and a Summary Plan Description to the participants and beneficiaries of the plan (within 90 days of when they become participants or beneficiaries) with a copy to the government. A summary of any material modifications in the plan terms must be provided to participants and beneficiaries within 210 days of the end of the year in which the change is adopted. ERISA, § 102, 29 U.S.C. § 1022, and § 104 (b)(1), 29 U.S.C. § 1024(b)(1).

The plan description and the Summary Plan Description must contain at least the following: the name and type of administration of the plan, the name, address and title of any trustee, the name and address of any agent for service of process, a description of any relevant collective bargaining agreement provisions, the plan's requirements for eligibility, a description of the plan's provisions governing nonforfeitable pension benefits if any, circumstances under which disqualification, ineligibility or loss of benefits will occur, funding sources of the plan, any organization through which benefits are provided, how the plan year is organized and when it ends, the procedures for claiming benefits under the plan, and the remedies available for redress when claims are denied in whole or part. ERISA, § 102, 29 U.S.C. § 1022.

> expense according to the provisions of the Prior Plan if it had stayed in force, or the benefit amount payable under this plan.

(Summary Plan Description at 31A, Exhibit 3, North Deposition.) Unlike Ms. Smith's previous coverage under Blue Cross/Blue Shield, the P.I.A. Centralized Health Plan limits skilled nursing facility benefits to a maximum of 180 days. (Summary Plan Document, 19A, Exhibit 3, North Deposition.)

The "Transition Provision" document circulated to employees at the employee seminars reads differently. The relevant portions are:

> •We will waive our pre-existing condition limit for everyone enrolled in your prior plan as of 11/31/86. . . .
>
> •If you or your dependents are in the hospital or disabled on 12/1/86, benefit payments will be those of your prior plan or our plan, whichever is less.
>
> •If you are currently disabled and receiving benefits under your current carrier, benefits will continue to be paid to you under the provisions of that policy, not ours.

("Transition Provision," Exhibit 2, North Deposition.) The final two paragraphs are at issue here.

B. North's Oral Representations.

Plaintiffs claim that prior to Nancy Smith's enrollment in the new plan, Beverly North represented to Joseph Smith that his wife's benefits would not change from those she had under the prior Blue Cross/Blue Shield policy. North pointed to the last paragraph of the "Transition Provision" document above, which states, "If you are currently disabled and are receiving

benefits under your current carrier, benefits will continue to be paid under the provisions of that policy, not ours." North told Smith that his wife fell under this final paragraph and not the one preceding it (which restricted coverage to the lesser of that provided by the old and the new plans) because his wife was already receiving benefits. ("Transition Provision," Exhibit 2, North Deposition, and J. Smith Deposition at 16-17.) North felt the preceding paragraph would only apply if the participant got sick or disabled *on* December 1, 1986. *(Id.* at 18.)[7]

For the purposes of this motion, the court will assume that Ms. North did make these statements, which is a reasonable inference given the following: North does recall speaking with Mr. Smith about whether his wife's medical coverage would continue, though she does not recall exactly what was said. (North Deposition at 15-16.) North also recalls being under the impression that benefits under the new plan would be as good as or better than those under the prior Blue Cross/Blue Shield plan and that employees would lose nothing under it. (*Id.* at 15, 19, 22, 23, 30.) She also recalls that she believed that "people that were covered under the policy that were in the hospital or disabled then would be continued, that they would be taken care of." *(Id.* at 24.)

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[7] Sandra Smith, a plan trustee and member of the plan's administrative committee at the time the "Transition Provision" was drafted, claims that the document contained an administrative error. The final paragraph was meant to apply to long-term disability insurance and not health insurance at all, and it should have been labeled that way. (S. Smith Deposition at 29-31.) The preceding paragraph, limiting coverage, was meant to govern health insurance coverage. *(Id.)* Apparently, the document was meant to be used at a number of hospitals, some of which had pre-existing disability insurance (S. Smith Deposition at 31) but the parties do not dispute that there was no disability insurance program at the Rehab Hospital. Smith believes the document was eventually corrected, but does not recall when the corrected version was sent to Rehab Hospital. *(Id.* at 34-35.)

III. LEGAL DISCUSSION: TO RECOVER BENEFITS DUE UNDER THE TERMS OF THE PLAN, AND ENFORCE RIGHTS UNDER THE TERMS OF SUCH PLAN.

Plaintiffs' second amended complaint seeks recovery under ERISA § 502 (a) (1) (B) and (a) (3), 29 U.S.C. § 1132 (a) (1) (B) and (a) (3). That portion of ERISA reads:

> *a) Persons empowered to bring a civil action.*
>
> A civil action may be brought—
>
> (1) by a participant or beneficiary—...
>
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;
>
> (2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 409 (29 U.S.C. § 1109) [breach of fiduciary duty];
>
> (3) by a participant, beneficiary, or fiduciary
>
> (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or
>
> (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provision of this title or the terms of the plan; . . . .

29 U.S.C. § 1132(a).

The court understands 29 U.S.C. § 1132(a)(1)(B) to offer quasi-contractual relief to participants seeking to enforce the entitlements granted by the explicit terms of a benefit plan. Section (a)(3), on the other hand, is addressed to equitable remedies.

IV. THE CONTRACTUAL CLAIM.

Plaintiffs argue several distinct ERISA claims, under 29 U.S.C. § 1132 (a) (1) and (3) cited above. Plaintiffs argue that the oral and written representations made to plaintiffs constituted an independent benefit plan enforceable under ERISA (this appears to be both a quasi-contractual claim under (a) (1) and an estoppel argument under (a) (3)), that the oral and written representations made to plaintiffs were plan interpretations enforceable under equitable estoppel, and that they were modifications of a plan enforceable under equitable estoppel. Plaintiffs also claim relief under a breach of fiduciary duty rubric. The following paragraphs deal with what the court reads as a quasi-contractual claim.

Defendants claim that the "Transition Provision" document quoted above and the North oral representations do not effect participants' rights under the P.I.A. VEBA Plan. Clearly, the P.I.A. Plan's Summary Plan Description, the explicit terms of which are discussed above, do not entitle plaintiffs to the relief they seek (coverage of Ms. Smith's skilled nursing care expenses up to a one million dollar limit as well as other coverage provided by the former Blue Cross/Blue Shield plan but not by the P.I.A. VEBA Plan). Any quasi-contractual claim by plaintiffs relies on finding a way to qualify the above document and representations as part of the contractual P.I.A. VEBA Plan. Plaintiffs wisely do not attempt to characterize these representations as contractual amendments to the plan as Third Circuit law would strongly discourage such an approach. *See Hamilton v. Air Jamaica*, 945 F.2d 74, 77 (3d Cir. 1991), *cert. denied*, 1992 LEXIS 1753 (1992); *Hozier v. Midwest Fasteners, Inc.*, 908 F.2d 1155, 1163-64 (3d Cir. 1990); *Frank v. Colt Industries, Inc.*, 910 F.2d 90, 98-99 (3d Cir. 1990).

Instead, plaintiffs have argued that these alleged oral and written representations constitute in themselves an enforceable employee benefit plan under 29 U.S.C. § 1132 (a)(1)(B). (*See* Plaintiff's Brief at 12). However, this court does not agree with this legal theory, and does not believe the Third Circuit would agree.

In *Gridley v. Cleveland Pneumatic Co.*, 924 F.2d 1310 (3d Cir.), *cert. denied*, 111 S. Ct. 2856 (1991), an employee was hired and given an insurance certificate which included a description of the terms of all of the company benefit plans, and a glossy overview brochure entitled Employee Benefits Summary, which contained brief descriptions of benefits, and referred the reader to Summary Plan Descriptions for more details. He never received any Summary Plan Description for the health and life insurance plan. The certificate (which he was given) and the policy itself (which he was not given) explicitly said that employees were eligible for increases in insurance benefits only if they were actively at work after the increase took effect; the overview brochure did not mention this limitation.

The employee signed up for an increase over the basic life insurance benefit, filling out an enrollment card which stated above his signature that he was an active full-time employee. Shortly thereafter he was stricken with a recurrence of cancer and never again reported to work. After he left work, the employer held a seminar, attended by the employee's wife, to announce the availability of new increases in basic life insurance benefits, and supplemental increased coverage which could be purchased as an option. A new overview brochure was given out at the seminar: neither the seminar presentation nor the new brochure mentioned the actively at work requirement. Another enrollment card for increases in life insurance was signed by employee. After his death, the employee's wife made a claim for increased benefits over basic

coverage, but it was denied, as her husband had not been actively at work subsequent to their purchase.

The *Gridley* plaintiff argued to the Third Circuit that the new overview brochure constituted a Summary Plan Description independent of the company's normal plan, and that she could recover benefits due under the terms of the brochure. The Third Circuit found a number of reasons to reject her argument, relying heavily on two points which are relevant here. First, the brochure actually contained a reference to Summary Plan Descriptions. Secondly, the brochure lacked the categories of information required of a summary plan description under ERISA. *See Gridley,* 924 F.2d at 1316.

Similarly, the "Transition Provision" document at issue in this case lacks the categories of information required by ERISA § 402(b) for a plan document: "a procedure for establishing and carrying out a funding policy and method" consistent with the objectives of the Plan and ERISA, a "procedure under the plan for the allocation of responsibilities for the operation and administration of the plan," a "procedure for amending such a plan, and for identifying the persons who have authority to amend the plan," and information on "the basis on which payments are made to and from the plan." 29 U.S.C. § 1102(b). The "Transition Provision" document also contains explicit language referring to "P.I.A. Plan deductibles", "our pre-existing condition limit," "benefit payments of . . . our plan" without explaining or defining these terms. It clearly refers to some other pre-existing plan. Hence, it is not an independent plan document. The oral representations made by North to Joseph Smith concerned only the continuation of Nancy Smith's coverage as before. They did not mention the other categories of information required of a plan document.

In response to this argument plaintiffs cite *Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir. 1982), for the proposition that a formal written plan is not a prerequisite for an ERISA plan: such a writing is only a reporting requirement once the plan is established. *Id.* at 1372. While *Donovan* did say this, it said more as well. The *Donovan* court noted that such a plan must be more than a decision to extend medical, disability, death or other benefits listed in ERISA: at a minimum there must be intended benefits, intended beneficiaries, a source of financing and procedures to apply for and collect benefits. *See id.* at 1371-72. A plan is only established if from the surrounding circumstances all of these can be ascertained. *Id.* at 1373. In *Donovan* they could. There was a single union trust, established by instrument to provide different types of insurance through the purchase of commercial insurance policies from insurers. The trust was subscribed to by employers and employees. The benefits and eligibility were set by the commercial policy terms and the insurers. There were participation agreements signed by employees and employers which clearly set forth who benefitted from and financed the trust. *Id.* at 1373-74. *Donovan* concerned no attempt to establish a "second" plan when one was already in place. For that reason, and because the representations and surrounding circumstances in the case at bar did not allow the above characteristics to be ascertained, *Donovan* is clearly distinguishable from the situation claimed here.

Given the above, the court would conclude that the written and oral representations in the case at bar did not represent an employee plan contractually enforceable under ERISA. To the extent that plaintiff relies on *Lipscomb v. Transac, Inc.*, 749 F. Supp. 1128 (M.D. Ga. 1990), to argue that the circumstances under which the representations were made in the case at bar merit their enforcement as a plan under an equitable estoppel theory, the court will address that below.

V. ESTOPPEL CLAIMS.

The court described the plaintiffs' estoppel claims earlier. The Third Circuit has stated that a federal common law estoppel action is available in ERISA cases like this one only in "extraordinary circumstances." *Gridley v. Cleveland Pneumatic Co.*, 924 F.2d 1310, 1319 (3d Cir. 1991) (citing *Hozier v. Midwest Fasteners*, 908 F.2d 1155, 1165 n.10 (3d Cir. 1990). Putting the extraordinary circumstances requirement aside, each of plaintiffs' estoppel claims depends on being able to show the elements of estoppel.

In order to prove an equitable estoppel claim a party must show "(1) a material representation, (2) reasonable reliance upon that representation, and (3) damage resulting from that representation." *Gridley*, 924 F.2d at 1319. The Third Circuit has explicitly stressed that *detrimental* reliance, injury or prejudice resulting from the reliance, must be shown. *Id.* at 1319-20 and n.8.

Ignoring the "extraordinary circumstances" requirement for a moment, even assuming that plaintiffs' legal theories underlying the equitable estoppel claims are appropriate, and that plaintiffs can show material representations and reasonable reliance, the court sees no evidence that they can prove injury from any such reliance. The plaintiffs make three arguments in this regard.

(1) They could have converted Nancy Smith's group coverage under Blue Cross/Blue Shield into a private policy which they would pay for in full. Neither party has the Blue Cross/Blue Shield contract in effect at the Rehab Hospital immediately prior to the time of the conversion. Defendants have a copy of the immediately preceding contract, and plaintiffs have a copy of the benefits booklet given to Nancy Smith explaining benefits available under the latest Blue Cross/Blue Shield contract. Under the contract defendants have pre-

sented, group policies are not convertible when an employer changes plans. (Blue Shield Medical-Surgical Agreement at 11 and Blue Cross Major Medical Agreement at 12, both at Exhibit 5 (A), Appendix to Defendants' Brief.) Plaintiffs rely on their benefit booklet to show injury; the only conversion privilege contained therein reads:

> If you leave the employ of the Hospital, due to termination of employment, layoff, disability or leave of absence, Blue Cross, Blue Shield and Major Medical coverage may be continued by converting to a Direct-Pay Subscription Agreement.

(Your Blue Cross and Blue Shield Benefits, Exhibit 5 (B), Appendix to defendants brief at 38.) However, the occasion for Smith's loss of Blue Cross/Blue Shield coverage was not that she left the employ of the hospital due to disability—it was that her former plan was cancelled in favor of another. Plaintiff has no evidence to suggest that any conversion privilege was available to Ms. Smith when her Blue Cross/Blue Shield group plan was cancelled in favor of the P.I.A. VEBA Plan.

(2) Mr. Smith could have shopped the market for alternative coverage. Plaintiffs have presented absolutely no evidence that any insurer would have been willing to insure Ms. Smith, someone with a pre-existing disability requiring full-time, apparently permanent, skilled nursing facility care. To the extent that no other possible insurers were known at the time, plaintiff is in the same position now as he was then, and has not been harmed by his alleged reliance on the representations cited.

(3) Mr. Smith, unemployed at the time, could have looked for a job which provided the group insurance coverage for his wife that she possessed under the prior Blue Cross/Blue Shield

plan. The court would make the same response to this as to (2) above.

Given the above, the court concludes that, even if the facts were as plaintiffs claim, they could not make out the elements of a normal equitable estoppel claim. Hence, they certainly would not meet the "extraordinary circumstances" standard for equitable estoppel set by the Third Circuit. Their equitable estoppel claims will be dismissed.

VI. BREACH OF FIDUCIARY DUTY.

ERISA § 502(a)(2), 29 U.S.C. § 1132(a)(2), explicitly sets forth a cause of action by a participant or beneficiary against a fiduciary for appropriate relief under ERISA § 409, 29 U.S.C. § 1109 [liability for breach of fiduciary duty].[8] This court had occasion to discuss at an earlier stage of this action *Massachusetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134 (1985). In *Russell* the United States Supreme Court held that a beneficiary may not recover extracontractual damages under ERISA § 409, a section which was intended to authorize relief only to the benefit plan itself. *Id.* at 140, 144. However, since the plaintiff in *Russell* did not rely on ERISA § 502(a)(3),[9] the Supreme Court reserved judgment on whether and under what circumstances a participant or beneficiary could recover

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8. Section 1109(a) reads

> Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this title shall be personally liable to make good to such plan any losses resulting . . . and to restore to such plan any profits of such fiduciary . . . made through use of assets of the plan . . . and shall be subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary.

9. Recall this is the section that authorizes equitable relief to enjoin acts violating ERISA or the terms of the benefit plan, or other equitable relief to redress such violations or enforce any ERISA provisions or terms of ERISA plans. See p. 13-14 of this memorandum for the relevant portions of ERISA § 502.

damages directly from a fiduciary under any other ERISA provisions. *Id.* at n.5.

In a concurring opinion joined by three other justices, Justice Brennan argued that the majority opinion should not be read to suggest that administrators were not subject to fiduciary duties to participants and to traditional trust law remedies for breach of those duties. *Id.* at 151-52 (Brennan, J., concurring). Brennan noted that "Congress intended by § 404(a) to incorporate the fiduciary standards of trust law into ERISA, and it is black-letter trust law that fiduciaries owe strict duties running directly to beneficiaries in the administration and payment of trust benefits." *Id.* at 152-53. He posited, admittedly in dicta, that appropriate equitable relief authorized by ERISA § 502(a)(3) might be available to individuals whenever a fiduciary violated the standards set forth in ERISA § 404(a). *Id.* at 153-54. ERISA § 404(a), 29 U.S.C. § 1104(a), dictates that a fiduciary "discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries" and for the exclusive purposes of providing benefits to such, and defraying reasonable administrative expenses. All of this must be done "with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims." 29 U.S.C. § 1104(a).

Some courts sitting post-*Russell* have interpreted *Russell* to say that there can be no fiduciary actions at all by a participant for individual relief. However, the Third Circuit has not yet taken a position on this issue. In *Hozier v. Midwest Fasteners, Inc.*, 908 F.2d 1155 (3d Cir. 1990), the Third Circuit labeled the issue "unclear," but found that case's facts made it unnecessary to "speculate as to the circumstances, if any, under which allowing individual participants to recover di-

rectly from a fiduciary can be justified under any of ERISA's *other* remedial provisions . . . ." *Id.* at n.7.

Plaintiffs here have brought such an individual fiduciary claim for violations of ERISA § 404(a), apparently under the authority of ERISA § 502 (a)(3), 29 U.S.C. § 1132(a)(3). Defendants argue that plaintiffs have not established any legal basis for the individual-type action they have brought, and that even if they had, (1) the Rehab Hospital is not a fiduciary and should be dismissed from this action, (2) there have been no breaches of duty by the P.I.A. VEBA Plan Administrative Committee, and (3) plaintiffs were not "participants or beneficiaries" of the P.I.A. Plan when the representations were made and thus no fiduciary duty was owed to them.

While the defendants are correct in that the plaintiffs have not set forth a legal basis for such a cause of action in the detail this court would have liked,[10] the court believes such a cause of action is theoretically a cognizable one.

The court would point to *Eddy v. Colonial Life Insurance Co. of America*, 919 F.2d 747 (D.C. Cir. 1990). In *Eddy*, the plaintiff had been diagnosed HIV-positive with one year to live. He scheduled exploratory surgery, recommended by his physician, but a few days prior to the surgery he was notified via written memo that the travel agency at which he worked was being sold, that his employer's group health policy would terminate on the day of his scheduled surgery, and that the new owner had not yet decided what type of coverage they intended to offer employees. When he was initially unsuccessful at finding alternative coverage, the plaintiff phoned the insurance company administering the existent plan, and inquired about conversion rights under his policy. He was told by an insurance company supervisor that he had no right to

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[10] They merely cite to this court's discussion of *Russell* in addressing a motion to dismiss earlier in the action at bar.

convert his group coverage to an individual private policy. He was forced to cancel his surgery, and his coverage ended. His health deteriorated, and he left his job shortly after the change in ownership. Ultimately, he somehow found out that he indeed did have the right to convert his coverage. The D.C. Circuit allowed plaintiff's claim under ERISA § 404.[11] The court suggested, in a similar vein to Justice Brennan, that the duties of an ERISA fiduciary were "not limited by that statute's express provisions but instead include[d] duties derived from common law trust principles." *Id.* at 750. The Second Circuit cited the Restatement (Second) of Trusts provision outlining the trustee's duty to "communicate to the beneficiary material facts affecting the interest of the beneficiary which he knows the beneficiary does not know and which the beneficiary needs to know . . . ," *id.* (quoting Restatement (Second) of Trusts § 173, comment d (1959)), to support the court's conclusion that a fiduciary must convey complete and correct material information to a beneficiary. *Id.* That duty was not discharged simply by adherence to ERISA reporting requirements but ran through all of the fiduciary's duties with the beneficiaries. *Id. See also Acosta v. Pacific Enters.*, 950 F.2d 611, 618-19 (9th Cir. 1991) (ERISA fiduciary's duty to disclose information to beneficiaries not limited to ERISA reporting requirements but may extend to additional disclosures where interests of beneficiaries so require).

However, even if this type of action is cognizable, and assuming plaintiffs can show both the existence of defendants' fiduciary status and the existence and breach of a fiduciary duty in their circumstances, plaintiffs' claim in the case at bar has a serious problem. That problem is a lack of causally related harm.

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11. See description of provisions of ERISA § 404 (a) at p. 24 of this memorandum.

In Justice Brennan's concurrence he refers to two possible models of redress: a remedy that "will put him [beneficiary] in the position in which he would have been if the trustee had not committed the breach of trust," *Russell*, 473 U.S. at n.16 (Brennan, J., concurring) (quoting Restatement (Second) of Trusts § 205 and Comment a (1959)), and a remedy to redress "harm caused by the breach of a duty arising from the relation." *Id.* (quoting Restatement Second of Torts § 874, Comment b (1979)). In *Eddy*, the court did not explicitly address the harm caused by the fiduciary's breach, but it was obvious in the court's statement that the plaintiff did, in fact, have the right to convert his policy. *Eddy*, 919 F.2d at 749. Payment of his accrued medical expenses under that policy would have met the models referred to by Brennan. *See also Vogel v. Independence Fed. Sav. Bank*, 728 F. Supp. 1210, 1228-29 (D. Md. 1990) (allowing individual recovery for breach of fiduciary duty under ERISA § 502(a)(2) for injury flowing directly out of the claimed breach).

Another instructive example is *Warren v. Society National Bank*, 905 F.2d 975 (6th Cir. 1990), *cert. denied*, 111 S.Ct. 2256 (1991), in which the Sixth Circuit addressed the trial court's dismissal of an ERISA action. The Circuit court adopted Justice Brennan's reasoning and concluded that a beneficiary could obtain equitable relief under ERISA § 502 (a)(3), 29 U.S.C. § 1132 (a)(3), to redress direct injury to a participant through an alleged breach of a fiduciary duty. *See id.* at 981-2. In *Warren*, the allegation was that the plan administrator had breached his contractual duty to carry out the plaintiff's instructions as to the distribution of plaintiff's assets from a group retirement plan. The court adopted the law of trusts remedy model cited by Justice Brennan above, putting the beneficiary in the position in which he would have been if the breach had not occurred. *Id.* at 982. The *Warren* court found that the plaintiff's claim that if the administrating

bank had done as the plaintiff had asked, his assets would be worth much more money, stated a loss which could be appropriately redressed. *See id.* at 982.

The common denominator here is injury. This court believes that a participant's claim for individual relief under a breach of fiduciary theory depends on showing that she was harmed by the alleged breach of fiduciary duty, that absent the breach, her situation would be different.

Plaintiffs were required to show this injury in another guise in their equitable estoppel claims. As discussed in the estoppel section above, this court has been presented with nothing to establish a question of material fact indicating that plaintiffs here suffered that injury. As a consequence, the fiduciary claim will be dismissed. An appropriate order will be issued.

/s/SYLVIA H. RAMBO
United States District Judge

Dated: April 16, 1992.

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

CIVIL ACTION NO. 1:CV-90-1541

NANCY M. SMITH and JOSEPH L. SMITH, Plaintiffs

v.

NME SPECIALTY HOSPITAL GROUP; PSYCHIATRIC INSTITUTES OF AMERICA, INC.; PENNSYLVANIA HEALTH CORP. d/b/a THE REHAB HOSPITAL IN MECHANICSBURG; P.I.A. VOLUNTARY EMPLOYEES BENEFICIARY ASSOCIATION GROUP INSURANCE PLAN; and P.I.A. VOLUNTARY EMPLOYEES BENEFICIARY ASSOCIATION ADMINISTRATIVE COMMITTEE, Defendants

ORDER AND JUDGMENT

In accordance with the accompanying memorandum, IT IS HEREBY ORDERED THAT:

1) Defendants NME Specialty Hospital Group and Psychiatric Institutes of America, Inc. are dismissed by agreement between the parties.

2. The motion of defendants Rehab Hospital, P.I.A. Voluntary Employees Beneficiary Association Group Insurance Plan, and P.I.A. Voluntary Employees Beneficiary Association Administrative Committee for summary judgment is GRANTED.

3. Judgment is hereby entered in favor of defendants and against plaintiffs.

4. The Clerk of Court is directed to close the file.

/s/SYLVIA H. RAMBO
United States District Judge

Dated: April 16, 1992.

TRANSITION PROVISION

0 ALL INSURANCE-TYPE PROGRAMS WILL COVER YOU 12/1/86 IF YOU ARE NOW COVERED BY YOUR HOSPITAL'S PLANS

0 ALL DEDUCTIBLES PAID BY YOU SINCE OCTOBER 1985 WILL APPLY TO MEETING PIA PLAN DEDUCTIBLES IN 1986. ALL CO-INSURANCE AMOUNTS PAID BY YOU SINCE JANUARY 1, 1986 WILL APPLY TO MEETING OUR CO-INSURANCE AMOUNT IN 1986. WRITE TO YOUR PREVIOUS CARRIER TO REQUEST VERIFICATION OF PAYMENT; SUBMIT WITH FIRST CLAIM.

0 WE WILL WAIVE OUR PRE-EXISTING CONDITION LIMIT FOR EVERYONE ENROLLED IN YOUR PRIOR PLAN AS OF 11/31/86

0 TO BE COVERED WITH NO PROOF OF INSURABILITY OR PRE-EXISTING CONDITION, YOU MUST ENROLL PRIOR TO DECEMBER 15, 1986, AN EXCEPTION TO THIS ARE EMPLOYEES WHO WERE NOT ENROLLED IN YOUR PRIOR PLAN AS OF 11/31/86. THESE EMPLOYEES WILL NOT HAVE TO PROVIDE PROOF OF INSURABILITY, BUT PRE-EXISTING LIMITATION WOULD APPLY.

0 IF YOU OR YOUR DEPENDENTS ARE IN THE HOSPITAL OR DISABLED ON 12/1/86, BENEFIT PAYMENTS WILL BE THOSE OF YOUR PRIOR PLAN OR OUR PLAN, WHICHEVER IS LESS.

0 IF YOU ARE CURRENTLY DISABLED AND RECEIVING BENEFITS UNDER YOUR CURRENT CARRIER, BENEFITS WILL CONTINUE TO BE PAID TO YOU UNDER THE PROVISIONS OF THAT POLICY, NOT OURS

for employees of

_____

Your Blue Cross and Blue Shield Benefits

...

Treatment by the provider in charge of the case for mental or nervous disease, drug addiction and/or alcoholism is limited to 30 days in any period of 12 consecutive months. Such days will be applied against the inpatient medical days available.

SKILLED NURSING FACILITY SERVICES

Benefits are provided for treatment in a skilled nursing facility. The subscriber shall be eligible if:

a. the subscriber's illness or injury requires at least three days of hospitalization.

b. the subscriber's condition requires skilled nursing care for continued treatment; and

c. the subscriber is admitted to the skilled nursing facility within 14 days following discharge from an accredited hospital.

These services in a skilled nursing facility are limited to two visits during the first week of confinement and one visit a week for each consecutive week of confinement thereafter. Each day of confinement in a skilled nursing facility counts as one-half day against the total 120 days available for inpatient medical services.

CONCURRENT CARE

(In Hospital)

Benefits are provided for inpatient medical services by a provider who is not in charge of the case but whose particular skills *are* required for the treatment of complicated conditions.

This does not include observation or reassurance of the patient, stand-by ...

... in a non-emergency situation only to transport the patient to or from a hospital for required treatment certified by the attending provider as medically necessary. No other charges for transportation or travel will be covered.

7. SKILLED NURSING SERVICES in semiprivate accommodations in a Skilled Nursing Facility* provided:

a. the patient's condition required at least three days of hospital inpatient care and he is transferred to the Skilled Nursing Facility within 14 days after discharge from the hospital;

b. he receives continued treatment for the same or a related condition for which he was being treated in the hospital; and

c. the attending physician certifies to the Plans that continued skilled nursing care is medically necessary.

*Skilled Nursing Facility means an institution which is not primarily for the care of mental illness or substance abuse and which is certified as a Skilled Nursing Facility by the Joint Commission on Accreditation of Hospitals or by Medicare.

BENEFIT PERIOD

Your Major Medical Benefit Period is a calendar year. You and each of your enrolled dependents are entitled to separate Major Medical benefits. Family expenses will not be combined.

...

PROCESSING YOUR CLAIM ...

APPROVAL

In consideration of waiving physical examinations of Subscribers, Blue Cross and Blue Shield are entitled to receive

and review any records from the patient's physician and hospital, such information to be kept confidential.

SUBROGATION

Subrogation seeks to conserve subscriber funds by imposing the expense for accidental injuries suffered by subscribers on those responsible for causing them. If you or one of your enrolled dependents should receive benefits under this Program for injuries caused by someone else, Blue Cross and/or Blue Shield, through subrogation, have the right to seek repayment of such benefits after the claim has been settled or litigation completed. Blue Cross and Blue Shield will, of course, provide benefits at the time of need; but you may be asked to execute and deliver such documents or take such other action as is necessary to assure the rights of Blue Cross and Blue Shield. Subrogation specifically does not apply to an insurance policy issued to and in the name of the Subscriber.

UTILIZATION REVIEW

You are entitled to receive benefits under this Program only when the services are or were medically necessary for the treatment of your illness or injury. Any service which is or was not necessary for your treatment will be at your expense, whether or not the benefits of your contract have been exhausted. Blue Cross and Blue Shield will determine, following utilization review, whether the services are or ...

for employees of
THE REHAB HOSPITAL
Nancy Smith

your Blue Cross and Blue Shield Benefits

... Clinical pathology services for which a hospital or institution bills for the technical component of the service and the provider bills for the professional component of the service.

Any other medical or dental service or treatment except as provided in this booklet.

GENERAL DESCRIPTION OF YOUR BLUE CROSS AND BLUE SHIELD MAJOR MEDICAL BENEFITS

GENERAL

Major Medical benefits supplement, but do not replace, Blue Cross and Blue Shield basic coverage. Major Medical is designed to cover the extraordinary expenses that occur during very serious, prolonged, or unusual illness or injury. It covers the reasonable, necessary, and customary charges for medically necessary hospitalization and medical benefits (Covered Medical Expense), subject to the provisions relating to the BENEFIT PERIOD, the DEDUCTIBLE, CO-INSURANCE, MAXIMUM AMOUNTS, and EXCLUSIONS.

You need not be hospitalized to qualify for Major Medical benefits, nor do you have to receive hospital care under the basic program before the Major Medical Program takes effect. Major Medical benefits may be used without the use of basic benefits, along with basic benefits or before or after the use of basic benefits.

HOW MAJOR MEDICAL WORKS

You are required to pay the first $100 of Covered Medical Expense in excess of your Blue Cross and Blue Shield basic

benefits. This $100 is called the Deductible. The Major Medical Program then pays 80% for the first $2,000 of Covered Medical Expenses (without regard to the deductible amount) per calendar year. Thereafter, 100% of eligible benefits will be covered up to a maximum of $1,000,000 during one or more calendar year Benefit Periods.

In the case of mental or nervous care, including drug addiction and alcoholism, 80% of the charges for Covered Medical Expenses for in-hospital cases and 50% of the charges for out-of-hospital cases are paid up to a nonrenewable lifetime maximum of $50,000 which is part of and not in addition to the overall lifetime maximum of $1,000,000.

The remaining 20% of Covered Medical Expenses or 50% in the case of outpatient mental or nervous care, is called a co-payment and is paid by you.

If for any reason, you or your dependents are not enrolled for Blue Cross or Blue Shield basic coverage, the benefits that would have been provided by the Basic Program will be deducted in determining your Major Medical benefits.

When you or an enrolled dependent require hospitalization or medical services of the type set forth below and the services are performed or prescribed by a licensed doctor of medicine osteopathy, podiatry, optometry, dental, surgery psychologist, chiropractic or physical therapist, such services will be covered, as follows:

1. Hospital charges for semiprivate room and board accommodations. For private room and board, the maximum amount allowed will be the hospital's most frequently established charge for semiprivate accommodations plus $10 a day.

2. Expenses for other hospital services required for medical or surgical care or treatment, such as operating

room, drugs, dressings, medicines, blood transfusions (including blood or blood plasma in excess of two pints, to the extent it is not donated or otherwise replaced), oxygen and administration thereof, anesthesia and administration thereof, and diagnostic x-ray and laboratory examinations.

3. Expenses for the professional services of a provider. Expenses for the services of a provider for mental or nervous care, including drug addiction or alcoholism, may not exceed $50 per visit.

4. Expenses in or outside the hospital for the services of a registered graduate nurse (R.N.), or a licensed practical nurse (L.P.N.).

Nursing services must be rendered by a nurse who does not reside in your home, or who is not a member of your immediate family. To be a covered service the provider in charge of the case must certify that the patient's condition requires care which can only be provided by an R.N. or L.P.N. and Blue Cross and Blue Shield must concur with the provider's certification that the care is medically necessary.

Coverage for nursing services shall be limited to 240 hours in any calendar year.

5. Expenses for the following services and supplies not furnished by a hospital:

a. Drugs and medicines requiring a provider's prescription and dispensed by a licensed pharmacists;

b. Diagnostic X-ray and laboratory examinations;

c. X-ray radium, and radioactive isotope therapy;

d. Anesthesia, oxygen, and administration thereof;

e. Blood and blood plasma in excess of two pints, to the extent it is not donated or otherwise replaced;

f. Rental of durable medical or surgical equipment.

g. Artificial limbs and artificial eyes, except replacements, necessary for the alleviation or correction of conditions arising out of accidental injury or illness.

h. Physiotherapy prescribed by the attending provider as to type and duration when performed by a duly qualified physiotherapist;

i. Orthopedic braces (except corrective shoes) and prosthetic appliances necessary for the alleviation or correction of conditions arising out of accidental injury or illness. Replacement of these devices is not covered except in the case of dependent children when certified by a provider as medically necessary. To be a covered service the Plans must concur with the provider's certification that the care is medically necessary.

6. Professional ambulance services when used to transport you or a covered dependent from the place of accidental injury or serious medical incident to the nearest hospital where treatment can be given. Professional ambulance service is covered in a non-emergency situation only to transport the patient to or from a hospital for required treatment certified by the attending provider as medically necessary. No other charges for transportation or travel will be covered.

7. SKILLED NURSING SERVICES in semiprivate accommodations in a Skilled Nursing Facility* provided:

a. the patient's condition required at least three days of hospital inpatient care and he is transferred to the Skilled

Nursing Facility within 14 days after discharge from the hospital;

b. he receives continued treatment for the same or a related condition for which he was being treated in the hospital; and

c. the attending physician certifies to the Plans that continued skilled nursing care is medically necessary.

*Skilled Nursing Facility means an institution which is not primarily for the care of mental illness or substance abuse and which is certified as a Skilled Nursing Facility by the Joint Commission on Accreditation of Hospitals or by Medicare.

BENEFIT PERIOD

Your Major Medical Benefit Period is a calendar year. You and each of your enrolled dependents are entitled to separate Major Medical benefits. Family expenses will not be combined.

DEDUCTIBLE

Since you and each of your enrolled dependents are entitled to full and separate Major Medical benefits, a separate $100 Deductible is applicable to you and to each of your enrolled dependents with these exceptions:

1. When family members are injured in the same accident, only one Deductible is applied toward the Covered Medical Expenses arising out of that accident.

2. Your family will not be required to pay more than three Deductibles in any calendar year.

A separate Deductible is payable during each calendar year in which Covered Medical Expenses are incurred. However, if you or an enrolled dependent incur Covered Medical Expenses during the last three months of a year, the amount incurred which is required to satisfy the deductible may be

credited toward the Deductible payable by you (or one of your dependents) in the following calendar year Benefit Period.

COINSURANCE

For general cases, Major Medical pays 80% for the first $2,000 of Covered Medical Expenses (without regard to the deductible amount) and 100% thereafter. You (or your enrolled dependent) pay 20% of these expenses up to the $2,000.

For mental cases, Major Medical pays 80% of the charges for Covered Medical Expenses for in-hospital cases and 50% of the charges for out-of-hospital cases and you (or your enrolled dependent) pay 20% or 50% of these expenses.

MAXIMUM AMOUNTS

1. General Cases: Major Medical pays up to $1,000,000 for you during your lifetime and up to $1,000,000 for each of your enrolled dependents. When you or one of your dependents have received $1,000 or more in benefits, Blue Cross and Blue Shield may reinstate the full maximum upon your presenting evidence of good health satisfactory to Blue Cross and Blue Shield. To apply for reinstatement an Application for Reinstatement of Maximum Benefits should be obtained from Blue Cross or the person handling your group and submitted to Blue Cross for review. For the employee, return to active, full-time employment for 13 consecutive weeks will restore the full maximum benefits provided an Application for Reinstatement of Maximum Benefits has been submitted to Blue Cross.

2. Mental Cases: Major Medical pays up to $50,000 for you during your lifetime and up to $50,000 for each of your enrolled dependents. This maximum is not renewable.

SEIDLE MEMORIAL HOSPITAL
Simpson & Filbert Streets
Mechanicsburg, PA 17055
(717) 766-7691

September 11, 1987

To Whom It May Concern,

In January 1987, I contacted Karen Davies at Rehab Hospital in regard to insurance coverage for Nancy Smith who is a patient in our Skilled Nursing Facility.

At that time, she could not give me any definite information but indicated that Nancy would be covered under their insurance plan with Hartford Insurance.

Also, on July 13, 1987, I sent copies of Nancy's Medical Records to Hartford Insurance as requested by Mr. Philip Christian.

Sincerely,
/s/Sandra J. Fertenbaugh
Patient Billing Supervisor

50 Years of Community Service & Committed to the Future
1937-1987

THE HARTFORD
The Insurance People of ITT

Health Claim Office
P.O. Box 11910
Alexandria, VA 22312
Telephone (703) 824-0600

August 26, 1987

Nancy M. Smith
c/o Joseph Smith
301 Charles Road
Mechanicsburg, PA 17055

Re: Skilled Nursing Care
Seidle Memorial

We would like to take this opportunity to express our regrets over the delay in the processing of your claims. Because, of the unique situation of your wife's hospitalization and the transfer of the Group's coverage, this was a complicated matter.

The payments issued were limited because of the transition provision. This section is located on page 31 of the Summary Plan Description, a copy has been attached with appropriate parts highlighted. We have also included the guidelines for skilled nursing facility care under this plan.

Simply put, your wife's stay, which also includes care covered by the previous carrier, has exceeded the maximum of 180 days in a skilled nursing facility. We regret that we could not be of further service at this time.

Should you have questions regarding this situation, please feel free to contact us at (703) 824-0600.

Sincerely yours,
/s/P.G. Christian
Claims Processor

cc: Seidle Memorial
120 N. Filbert Street
Mechanicsburg, PA 17055

mh/3878A/1

Hartford Fire Insurance Company and its Affiliates
Hartford Plaza, Hartford, Connecticut 06115

THE HARTFORD
The Insurance People of ITT

Health Claim Office
P.O. Box 11910
Alexandria, VA 22312
Telephone (703) 824-0600

December 6, 1988

Mr. Joseph Smith
301 Charles Road
Mechanicsburg, PA 17055

Re: Nancy Smith
Seidle Memorial, October, 1988

Dear Mr. Smith:

We are in receipt of the above mentioned claim for your wife. This claim for a total of $22,601.29 is for skilled nursing care.

We regret to inform you that we must deny benefits for this claim. Under the terms of PIA's Plan Document and the transition provision of that document, Hartford has met its liability for skilled nursing care.

In a letter dated May 3, 1988, to David Ditzler, Investigator for the Bureau of Consumer Affairs, we had indicated that we would extend our coverage forty-five (45) days beyond February 22, 1988 as an exception and beyond the normal scope of the plan guidelines.

We do regret that our decision in [sic] an unfavorable one. However, should you have problems or questions regarding this matter, please contact Mr. David Eakin at 1-800-368-3653, Extension 158, Monday through Friday, 8:00 a.m. to 4:30 p.m.

Sincerely,
/s/Phillip Christian, Health Claim Processor
Washington DC Health Claims Office
HARTFORD SPECIALTY COMPANY
6371A/1

Hartford Fire Insurance Company and its Affiliates
Hartford Plaza, Hartford, Connecticut 06115

June 19, 1989

Hartford Insurance Co.
Mr. Eakin

Re: Nancy M. Smith
Appeal of Benefits

Dear Mr. Eakin,

In reply to your letter dated December 6, 1988 which denied claims for Nancy's benefits totaling $22,601.29 for skilled nursing care.

The Hartford stated that they denied the claims under the term of P.I.A. Plan Document and the Transition Provision of that document, P.I.A. waived their pre-existing condition limit for everyone enrolled in a prior plan as of 11/31/86 such as in a new acquisition. The Hartford has not met its obligation for her benefits.

Nancy was not disabled on 12-1-86, she was disabled on 8/27/85 and already receiving benefits under Blue Cross & Blue Shield under P.I.A. Transition Provision she would have had to be disabled on 12/1/86 in order for you to pay benefits of the prior plan or your plan which ever is lesser. Is there a question on what date Nancy became disabled?

Does The Hartford denie the P.I.A. Transition Provision that the Director of Personnel Department of the Rehab Hospital in Mechanicsburg, Beverly J. North gave us are valid. I don't think Blue Cross & Blue Shield had any limit on Nancy's benefits.

The Hartford my stop paying Nancy's benefits, as they have done, but this doesn't indicate that The Hartford has met and up held its obligation for her benefits, as in accordance to their Transition Provision. The Hartford has decline to our question, as to how you can stick Nancy under a Provision that is favorable to the Hartford and not have anything to do with

Nancy's claim. I hope we will be able to get an answer to the question that I have been asking for the past year or so, in regards to a clarification of "The Transition Provision" and to date I have not been answered properly. We feel that the exception that was made, was not made in favor of my wife, but is cost cutting for Hartford. In every letter The Hartford tells me that should I have a problem or a question regarding this matter, please contact Mr. Eakin, still to this date no one has answered my questions. Hope to hear from someone concerning this matter in the near future.

Sincerely
/s/Joseph L. Smith
Nancy M. Smith
c/o Joseph L. Smith/Spouse

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*Errata in original.

The Hartford
The Insurance People of ITT

Health Claim Office
P.O. Box 11910
Alexandria, VA 22312
Telephone (703) 824-0600

July 14, 1989
Mr. Joseph L. Smith
301 Charles Road
Mechanicsburg, PA 17055
Re: Nancy Smith
PIA—608
Dear Mr. Smith:

Your letter of appeal was forwarded to PIA's corporate office for further review.

PIA has authorized one final extension to pay all eligible costs incurred between April 8, 1988 to the date of their approval June 15, 1989, so long as you accept and sign to this effect. This will be full and final payment from the Plan for Mrs. Smith's condition.

Please sign below in the space provided if you are in agreement to PIA's condition.

Sincerely,
/s/S. L. Downs, Supervisor
Washington DC Health Claims Office
HARTFORD SPECIALTY COMPANY
By:_____
Joseph Smith
Date:_____
6807A/6

Hartford Fire Insurance Company and its Affiliates
Hartford Plaza, Hartford, Connecticut 06115

August 2, 1989
Re: Nancy M. Smith
P.I.A. 608
Dear Mr. S.H. Downs:

In response to your letter dated July 14, 1989 in regards to payment of benefits for Nancy M. Smith for the period of April 8, 1988 until June 15, 1989. The letter is very vague, if I'm not mistaken the letter states that if we sign the letter we are not going to receive benefits for Nancy in the future? If that is the case why must Nancy give up her future benefits in order to collect her past unpaid benefits?

Is Nancy to assume that id she doesn't sign and accept P.I.A. Agreement that you will continue to not pay her past and future benefits as you have been in the past. This fight for her benefits has been draging on for almost three years or more. She is disabled and really shouldn't have to worry all the time if you are going to pay or not. I think that this whole matter has had a callous manner to it.

P.I.A. might not pay Nancy's benefits but you are still liable to her and she is entitled to them. Your Corporate Lawyers has been provided with the evidence that validates her claim and aligations, and it is bonding and legal.

This situation places Nancy's whole future in jeopardy. I am sure that when other people ask questions about their claim P.I.A. responds to the question; so why after three years of asking questions abouts her claim Nancy has yet to receive an answer.

I would like to know exactly what the letter means, in simple language. I would like to know exactly what your intensions are as far as paying her claim as you know you should.

Will be expecting an answer from you in response to this letter if that is at all possible.
Sincerely,
Joseph Smith for Nancy Smith

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*Errata in original.

THE MECHANICSBURG
REHAB SYSTEM
Rebuilding Independence

MEMORANDUM

TO: Employees with Hartford Medical/Dental Coverage

FROM: Shari M. Kyle
Director of Personnel

DATE: November 8, 1989

SUBJECT: Claims Administrator Change
Effective December 1, 1989

We are pleased to announce that *effective this December 1* the Provident Life and Accident Insurance Company will place the Hartford as claims administrator for The Specialty Hospital Group medical plan. This change is being made to improve the quality and timeliness of claims processing, and in *no way changes the benefits provided under these plans nor your employee deduction toward the premium.* Provident is a significant company in the insurance industry and we are confident that it will well serve your claim filing needs.

Because there will be a period of four weeks or longer when no claims are being paid while the Provident receives, verifies and enters claims histories on all subscribers, you will want to *file all your claims now with the Hartford, but not after November 15.* They are taking about two weeks to process each claim and will stop all processing on November 22 at which time they will transfer all records to the Provident. Provident will begin actual processing no later than December 18.

The attached question and answer piece is designed to advise you of other critical information that will help make the transition go as smoothly as possible for you. These attachments are:

—*Questions and Answers* —The SHG Benefits Department anticipates and answers the questions you most likely will have concerning this change.

—A *Transition Timetable*—This is an important explanation of when to stop and start sending your claims to the Hartford and Provident among other critical information.

Please take a moment now to review this information and keep it handy as a reference to answer questions throughout the transition process.

Attachments

175 Lancaster Blvd. , P.O. Box 2016,
Mechanicsburg, PA 17055 (717) 691-3700
A Subsidiary of *Rehab Hospital Services Corp.*

Provident

Name: Nancy M Smith
Operation Location Number: 08096 9 0000608

Provident Claim Office
1001 Boulders Pkwy, Suite 250
Richmond VA 23225-5513

Nancy M Smith
301 Charles Road
Mechanicsburg PA 17055-3004

Claim Type
Medical

Reference Number	ID Number
0339003001756	144-54-1148

Date Processed	Service Date
03/12/90	082687-123187

Patient-Name/Relationship
Nancy M Smith/Self
Plan Name
Specialty Hospital Group

Dear Mrs. Smith:

We are in receipt of your hospital bill from 1987.

The time limit for filing claims has expired. You have only one year from the date the expense was incurred to file the claim with the plan administrator.

If there were extenuating circumstances which prohibited you from filing these expenses within the one year period, please advise our office of the reasons.

Under the terms of the policy you do have a right to an appeal within 90 days after the claim has been denied. We will respond back to you within 60 days after receiving the appeal.

If special circumstances are involved in reaching a final decision you will be told of the reasons for the delay within 60 days of your request for appeal. In any event, you will receive a final decision within 120 days of the date of your request for appeal.

Sincerely
Provident
Group Claim Service
R15-CAM
L#034-000 031090 001196 E

March 21, 1990
Provident Life and Accident Ins. Co.
1001 Boulders Parkway, Suite 250
Richmond, VA 23225-5573
RE: Nancy Smith
REF #—0339003001756
ID#—144-54-1148
Appeal Decision Date—March 12, 1990
Group Claim Service:

My claim was filed with the Hartford Insurance Company in 1987 and my benefits were paid up to April 8, 1988. I have sent you a copy of The Hartford letter dated (february 22, 1988) confirming payment of those benefits.

After not receiving any benefits after April 8, 1988, I filed another Appeal on June 19, 1989 to have these benefits paid on July 14, 1989.

PIA's Corporate Office authorized payment of all eligible costs incurred between April 8, 1988 to the date of their approval, June 15, 1989, payable only if I sign an agreement to give up all future benefits in order to receive my past benefits, which I did not agree with nor did I sign the agreement (a copy of this agreement dated July 14, 1989 is enclosed for your records.

An Appeal to this agreement was filed on August 2, 1989 and to date I have not received a reply.

The claim filed with Provident is for these benefits starting April 8, 1988. PIA's Corporate Office has reviewed my Appeals and they have made a decision and authorized payment on my claim. They also have all of my Appeals. It's incomprehensible that you have refused my benefits on the grounds that the time for filing claims had expired.

Sincerely,
Nancy Smith

NS/mja